

HARVARD MEDICAL

ALUMNI BULLETIN

SUMMER 1982



*The Week
That Was*



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HARVARD MEDICAL

ALUMNI BULLETIN/SUMMER 1982/VOL. 56, NO. 3

FEATURES

- 13 **A Bicentennial Trilogy**
13 **Introduction** by William B. Castle
14 **The Pilgrim Legacy** by Thomas Boylston Adams
17 **Harvard Medical School, 1870-1920** by Kenneth M. Ludmerer
22 **Harvard Medical School and Medical Education in the Twentieth Century**
 by Gert H. Brieger
- 26 **The Rites of Spring '82**
- 30 **Alumni Day**
30 **Asklepios and Zeus** by Victor W. Sidel
33 **In Philadelphia They Ask — Who Were His Parents?** by John L. Lewis
35 **A Near Fatal Case of Potomac Fever** by George A. Bray
37 **Life Among the Giants** by John P. Merrill
40 **The Letter That Saved My Life** by Walter Pick
43 **A History of the Harvard Medical Association** by Jane G. Schaller
- 46 **Class Day**
47 **How Are You Feeling?** by Daniel A. Goodenough

DEPARTMENTS

- | | | | |
|---|--------------------|----|------------------------|
| 2 | Inside HMAB | 10 | Student Forum |
| 3 | Letters | 50 | Reunion Reports |
| 6 | Bookmarks | 57 | Alumni Notes |
| 8 | Pulse | 63 | Death Notices |

INSIDE H.M.A.B.

Alumni Day became Alumni Week as Harvard Medical School ushered in its Bicentennial Year at the beginning of June. An acre of smartly set tents, a lion rampant on a crimson field, new pennants accentuating the massive vertical columns of Building A, all lent a chivalric air to the proceedings. One felt certain that jousting must be going on somewhere.

The Class of 1932, a half-century out of school, was the harbinger of the official Bicentennial pronouncement, offering a first day of illuminating talks which closed with a panel that included Bigelow, Churchill, Holmes, Warren, and Welch, Harvard's Minister Extraordinary to the Vatican. And then to cap it all, a banquet and fireworks, a *grande illumination* over the Charles River Basin, a real surprise for the patients at the Massachusetts General Hospital and the settlers on Beacon Hill.

Needless to say, the week produced an editorial surfeit. In these pages our Alumni Day speakers address us with traditional wit and relevance, Daniel Goodenough speaks to the Class of 1982, and three historians offer a Bicentennial trilogy: T. B. Adams takes us back to Leyden and the origin of the school with John Robinson and the Pilgrim tradition, Ludmerer speaks of the Eliot days, and Brieger of the school as we have known it since 1920. And to please the Alices among us, there are lots of pictures, including the newest of our alumni and their Class Day.

It was a week of celebration, a portent of things to come — the Convocation in October. What editorial joys lie ahead?

— Gordon Scannell

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ALUMNI BULLETIN

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An Emphasis on Stress

It seems reasonable to assume that such problems as depression, substance abuse and suicide in physicians, as in other human beings, are the result of complex interactions among many factors. Some of these are:

1. Genetic endowment
2. Early childhood experiences
3. Later developmental experiences
4. Current physical condition
5. Stresses of current personal life
6. Stresses of current occupational life

It is disturbing to see Peter Reich, in the recent issue of the *Bulletin*, making such a determined attempt to eliminate the factor of occupational stress from this list. He seems to be saying, "We don't have to look at the educational practices and attitudes in medicine because the problem, if there is a problem, lies elsewhere."

Of course, it does not make sense to blame the profession of medicine for all the problems of physicians. Each situation should be studied individually to determine the relative importance of the various factors involved. This approach has been well described by George Engel, M.D., of the University of Rochester, using a biopsychosocial model. As one component, occupational stress of physicians is important because constructive change is possible there.

My study of, and experience with, the problems (including my own) of members of the helping professions has led me to the following conclusions:

1. We should, as George Vaillant said in his article in the *Bulletin*, give ourselves permission to ask for emotional support, care and help as needed. Unfortunately, the sense of

shame about needing psychiatric or even medical care is still very strong among physicians.

2. We should choose to emulate as our ideal physician one in whom the needs for professional achievement, service to others, financial remuneration, and a satisfying personal life are in some reasonable balance. The current ideal is heavily overloaded on the achievement portion.
3. We should recognize that we each have distinct talents, capabilities, needs and proclivities and judge ourselves by how well we do with what we have, avoiding the futile attempt to be what someone else thinks we should be. The academic physician (mentioned by Richard Reiling) who disparages the "LMD" or any other medical career may certainly make it difficult for some young physicians to find their own reasonably comfortable but productive niches.

We must keep studying, thinking and talking about such tragedies as the deaths from the Class of '67. Thank you for devoting some of the *Bulletin* to this subject.

Tracey McCarley '48

The articles on stress were an excellent exploration of some of the issues I raised in a letter to the *Bulletin* last year [quoted on pages 2 and 18 of the winter issue].

The fact that the mortality experience of my class regarding both the age and mode of death is similar to that of

other classes is very distressing. I hope the medical school and alumni can begin to develop a program to prevent this tragic waste of lives and resources.

Karl Singer '67

Never before have I responded in print to comments about my novel, *The House of God*. However, to suffer distortion in the bulletin of my *alma mater* is something that I dare not let pass. I refer to Dr. Casscell's article in the winter issue.

Two points:

- 1) When one uses footnotes, it is important not to use them to distort information. Dr. Casscells writes that the book was "pilloried" in the *New England Journal of Medicine*. Either Dr. Casscells is being malicious, or has failed to do his homework, for, while an initial few letters were angry and defensive, the next batch, written in reaction, were supportive and enthusiastic (See *NEJM* 305:1288-1289, 1981).
- 2) Dr. Casscells writes that *The House of God* was "written in the heat of an anger so blinding..." Shame on you, Dr. Casscells! If you were any kind of a writer you would realize that, first of all, it is folly to pretend to know an author's motivation, and, secondly, while original motivations may spring from great passion, after four years' work and seven rewrites a novel takes on a life of its own, and the author's motivations become only this: to be a vessel for what "is," and to try and

write what one anthology has called "the best novel ever written about doing an internship" (*Medical Self-Care*, Ferguson, Ed., Summit Books, 1980, p. 187).

Samuel Shem
(Stephen J. Bergman '73)

Relative to the winter *Bulletin*, on stress: In my professional experience as a psychiatrist and psychoanalyst, the conflicts which produce suicides such as those of the class of '67 are less often caused by conflicts with current external stresses than they are by the stresses of internal conflicts which exist long before medical school. It is correct to look first at the simplest etiology—stresses of daily life—but the answer may lie much more in the internal causes that break through under specific external stresses.

Leon J. Saul '28

The winter issue of the *Bulletin* is a good one, especially the brief piece on the stresses of practicing medicine in the '80s (page 30) and the interview with Peter Reich.

I naturally look in the Alumni Notes for news of the class of 1917, and I assert my right to be critical of the notes. Joe [Wearn] does not spell his name the way you have it, but I will not risk recording how he *does* spell it. I know, too, that Cicero did not spell "old age" in Latin with a letter "r" and no letter "u". Anyway, thanks for apprising us of Joe's whereabouts, and this is a hello from his old classmate, patient, student, colleague, and fellow member of the Balcony Committee.

Karl Menninger '17

I have just finished the winter issue of the *Bulletin* and am as pleased with the quality and interest of the subjects there addressed as I was with the fall issue.

Unavoidably my wrath was waxed by the letters of J. Russell Smith '32 and Merrill J. King '52, who apparently want to return to the good old days of pleasing pabulum about former greats and no stylistic changes, please. Their criticism of the efforts of the editorial staff are so unfair as to prompt this letter encouraging you all to keep up the good work.

I guess the only way that those of us now over 60 and looking starkly at onrushing senility can understand what's happening in the student and resident body would be a short *locum tenens* at school or hospital. I can only remember much interest and excitement, a lot of support from the teaching and clinical staff, and a sense of privilege to be there at all. My children advise me regularly about change and the limited knowledge base from which my generation operates, but I can't really believe the species, particularly sub-variant *medicus*, has changed as much as present-day comment sometimes suggests.

The more we can learn about change in the once familiar HMS milieu the better. This is what I believe you and your staff are expertly providing to us.

Thomas Rutter '45

Joie d'Etudier

"Chance favors the prepared [or preparing] mind."

The cluster of articles and letters in the *Bulletin* about the existence of experiences in premedical and medical school that result in "torture" and "dehumanization" of the current crop of young doctors saddens me. Seen from the vantage point of age, one blames poor curricula; poor teachers; concentration on detail and not principles; and a generation that has grown up without learning that all work and no play retards the learning process.

As Winston Churchill pointed out, it is what one does in one's play time that strengthens one's ability to handle stress. In the 1930's we were often short of money, but never of outstanding teachers who taught us principles of patient care that provided knowledge, growth, and a sense of humor, as well as to enjoy life and not take oneself too seriously.

In those years the National Board Examinations were just coming to the fore, and at Harvard it was optional for the student to take them. Many of us did; and since it was our choice, preparation was our responsibility. The Part I examination in 1932 was scheduled a week after formal classes ended at HMS. Three of us—Stillman, Tracy, and I—decided to do our reviewing of the basic sciences in the country. Tracy had a lovely summer

home on Silver Lake in New Hampshire, and his mother arranged for a lady to cook our meals. We agreed we would study five hours each day.

Non-study time immediately took on aspects of medicine. Tracy's fox terrier encountered a porcupine and had his face and shoulders impaled with over fifty quills. The local veterinarian seemed to have served in the Spanish-American War and was under the weather. He did sell us a can of ether and lent us a metal drip cone that must have been stolen from the Ether Dome museum. Our training in anesthesia at the Women's Free Hospital and the dog surgery course had been excellent. It is easier to remove quills than fishhooks.

Another afternoon we were joined by two college girls as we started up the Piper Trail on Mt. Chocorua. On our arrival at the bare summit we found a thunderstorm heading toward the mountain. One of the girls developed an acute panic state and was terrified beyond control. How we wished we had listened more carefully to Macfie Campbell's evening seminars at his home in Cambridge instead of ogling his attractive daughters. But the frightened girl was reassured by the empathy and support we provided.

Tracy had a sailing canoe, and if there was a breeze we sailed. One afternoon an elderly man hailed us from the shore, complimented us on our sailing and asked what we were doing so early in the summer. We replied that we were medical students from Harvard "studying" for board examinations. "Oh," he said, "I used to teach there. Come have some tea and talk. My name is Theobald Smith." We listened for hours as he talked about his studies in tuberculosis, undulant fever, and Zinsser's contributions in typhus fever.

The next week back in Boston we took the examinations. The Bacteriology section was largely made up of questions on tuberculosis, brucellosis and the rickettsial diseases. Chance does favor the preparing mind. Play it again, Theobald.

Thomas Warthin '34

Reflections on the Darsee Affair

I am sure you have probably received more gratuitous comments on the Darsee affair than you care to read (least of all, publish), but as one who

"opted out" of the academic rat race, I can't refrain from putting in my two-cents' worth.

When two such incidents occur within two years at such prestigious medical schools as Yale and Harvard, one cannot but suspect that these may be only the superficial symptoms of a systemic disease.

The article in the recent *AMA News*, based on an interview with Dean Tosteson, refers to the "love of discovery" exemplified by researchers such as John Enders. As one of their pupils, I have often wondered what Hans Zinsser and John Enders would think if they were reincarnated and sat on an NIH review panel, reviewing the grant proposals submitted in carload lots by our modern research establishment. I suspect they would be shocked rather than overcome with admiration.

Certainly one cannot have excellence without a powerful motivation to succeed, but in scientific research it seems to me that that motivation must be internal, not external. The investigator must be driven by a peculiar "love of discovery" that cannot be mass-produced, but may exist only as the result of rare genetic mutation. This drive must also be tempered by a scrupulous honesty and objectivity which seems to be discouraged—or at least ignored—in our present educational system.

Just what should be done to curb the spread of this disease is not so apparent. It is hard to find many John Enderses and Hans Zinssers in our modern medical schools to serve as role models for young investigators, but I'm sure that from the rich genetic stock available in this country such mutations will again arise. Let's hope that we can create and perpetuate a milieu conducive to their survival.

E. Langdon Burwell '44

Is There Death Before Life?

I used to dislike proofreading; however, lest the following succeed by eminent domain, I hesitate little in pointing to page 20, paragraph 3 of the spring *Bulletin*: "Oliver Wendell Holmes was born in 1809..."; and later in the same paragraph, "Holmes died in 1804..."!

At first I thought this was a classic case of heart success "where the heart beats better and better 'til time runs

backward." Then I assumed that the 8 was the error (being unsure of the death age of OWH), but finally discovered in the last paragraph that the 0 was the culprit—which indeed made more sense.

All in all, though, a magnificent issue, from which I became more erudite and knowledgeable in quick steps.

David Dove '42

Alive and Well

Although I was flattered when my former residents and associates chose to present the West Virginia School of Medicine with the portrait mentioned in the Alumni Notes section of the winter *Bulletin*, I am concerned that your write-up could be misleading. I am still alive, teaching, and practicing surgery full-time at the West Virginia School of Medicine. I resigned the position of chairman but continue as professor in this department.

Bernard Zimmermann '45

The editors welcome letters from readers, particularly in regard to articles published recently in the Harvard Medical Alumni Bulletin. Letters should be brief, double spaced, submitted in duplicate, and marked "for publication." Not all letters can be used; those accepted will become the property of the HMAB and may be edited, although we are unable to provide pre-publication proofs.

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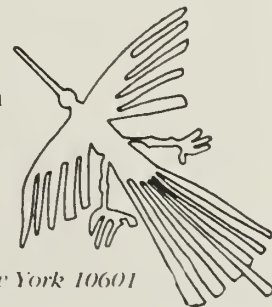
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Beyond Freud and *Playboy*: A New Look at an Old Taboo

FATHER-DAUGHTER INCEST, by Judith Lewis Herman, with Lisa Hirschman, Harvard University Press, Cambridge, 1981.

by Roberta Apfel

"Incest is *not* a topic that one embraces; one backs into it, fighting every step of the way." In *Father-Daughter Incest*, Judith Lewis Herman (HMS '68) has fought all of our usual wishes *not* to look at incest. From clinical observations with collaborator Lisa Hirschman, a clinical research project, and extensive literature review, Herman has written a useful and comprehensive textbook. Interwoven in the fabric is a feminist perspective that goes beyond speculation and explanation to a polemic against patriarchal society—a polemic which unfortunately obscures rather than enhances material that is in itself startling and thought-provoking.

Written expressly for both incest victims and professionals in the mental health field and legal services, *Father-Daughter Incest* is the first professional book on this most extreme form of sexual abuse—a topic that has already received popular media attention for about five years.

When, in the last decade, we started to talk about the formerly taboo subject of rape, blamed the victim less, and admitted the violent nature of that crime, rape reporting increased—and women who had carried the secret stigma of rape for decades appeared when the climate changed. Now the new openness about incest will inevitably prompt more people to ask for professional assistance.

Herman's introduction squarely sets incest as a universal theme, but she claims that incest is explicable *only* with frankly feminist ideology. Increased feminism has certainly in-

creased consciousness about incest, but I do not find the feminist perspective an adequate one from which to fully explain incest practice.

Throughout the book, for example, in trying to explain the fascinating fact that adult men commit incest far more than women do, Herman keeps

For the physician, this book will not only raise consciousness on an important public health problem, but will also raise potentially disturbing questions about his/her own lifestyle.

coming back to the nature of the patriarchal society. It would be interesting to study matrilineal societies to test her hypothesis that "the greater the degree of male supremacy and the more rigid the sexual division of labor, the more frequently one might expect the taboo on father-daughter incest to be violated."

The book is divided into three sections. The first, *The Incest Secret*, is the most immediately informative; it reviews theories and studies of incest incidence. Consensus is apparent in the finding that father-daughter incest is the most prevalent type and occurs in families that often appear otherwise normal. Mother-son incest occurs very rarely and involves bizarre situations; mother-daughter incest is virtually non-existent.

Surveys of white middle class individuals and college students reveal

astonishing rates of sexual abuse of children. Some 25 percent of prepubescent females have been abused by an adult male, though fewer than one percent by the father or stepfather. Male children also report high rates of sexual abuse, and there too the aggressor is an adult male over eighty percent of the time.

Herman claims that the data from Kinsey's survey—which amassed the largest number of incest cases collected from a house-to-house survey—have been suppressed and have not been made available for study. I cannot question the claim, but I do wonder about her tone, which suggests conspiracy.

Herman's feminist perspective also colors her discussion of Freud, whom she accuses of having "falsified his incest cases." My superficial perusal of the original sources does *not* substantiate the author's conclusion that Freud incriminated daughters rather than fathers to save his own neck.

Freud struggled to understand and explain what he saw in his patients, and his reversals and shading to different positions were not limited to his views on women. (A most readable and scholarly discussion of Freudian notions about seduction is contained in *Freud's Early Psychology of the Neuroses* by Dr. Kenneth Levin of the HMS faculty.)

One of Herman's most valuable discussions concerns definitions of incest; there is no doubt that the level of harm increases when the sexual abuse is more extensive. The clear line, though, is not sexual intercourse as a

Roberta Apfel is Assistant Professor of Psychiatry at HMS, Chair of the Joint Committee on the Status of Women, and is affiliated with the Beth Israel Hospital.

biologic definition or legal statute might have it.

Herman uses a psychological concept, defining as incest any sexual relation between a child and an adult in a position of parental authority, blood relative or not. Serious and equivalent harm results from any sexual "play" that requires secrecy. She points out that popular magazines of the *Playboy* ilk still blame the daughter for being seductive, or the mother for being neglectful of her husband, to rationalize incest as acceptable behavior.

Part two is about *Daughters' Lives*, and offers vignettes from interviews with women already in therapy. Forty incest victims are compared to a group of twenty women with seductive fathers who had stopped short of incestuous behavior. These women in therapy were probably better off than incest survivors out of treatment; the sample is skewed in the direction of the more organized of the spectrum.

The groups are well-matched and show many superficial similarities, especially that the families were patriarchal, with conforming and competent fathers. However, among the incest group, fathers were significantly more violent; and mothers were sicker, more often absent, oppressed, and had many more children—for whom the incest victim often assumed a maternal role.

Herman uses poignant clinical cases and quotations from these incest survivors to illustrate her findings of the long-term effects. The women as quoted speak eloquently for themselves. "I feel I have a sign on me saying, 'Walk all over me,'" one reports. "I'm afraid to fight; I could lose. I don't know what my rights are." In a section presenting views of parents, the adult daughters' tendency to protect the father, rationalizing his action while blaming themselves and their mothers, is painful to read.

A history of incest is associated with impairment later in life of the normal mechanisms of self protection. Herman's examples include adolescent runaways, prostitutes, battered women, drug and alcohol abusers, and some rape victims. She finds that personal relations are often deeply disturbed, though many incest victims show remarkable work achievements.

Physicians should be aware of some correlation of somatization disorders (not cited in Herman's book) with past incest. One percent of

females have this disorder, rarely diagnosed in males, that begins before age thirty and includes sickness and complaints of at least fourteen symptoms. A year rarely passes for those afflicted without medical treatment, hospitalization, and even surgery. Clarification of an incest history and appropriate psychiatric referral can be helpful to the patient and her doctors.

The last section of the book, *Breaking Secrecy*, is a "how to" guide based on experience of innovative programs visited by the authors. There is a realistic appraisal of the difficulty and the importance of reporting child abuse (indeed there is a legal imperative to do so in Massachusetts and other states). This section is most helpful to the child protection worker already familiar with services to families, shelters, and with community regulations. The physician who sees many early signs and late sequelae of incest will need to refer to agencies in the local community.

I found that this section became tedious and repetitive. Lengthy descriptions of various treatment programs lead to the conclusion that there is no single solution to the multidimensional problem of incest. Herman makes clear that successful programs, still few in number, work with the entire family network in crisis. The father may need to be removed from the house, the mother bolstered with support, the daughter seen intensively, the other kids cared for.

Dr. Herman's conclusion—developed from her feminist perspective—is that sexual abuse can be prevented by integrating men into children's lives; this is a worthwhile goal, to be sure, and for many reasons. I hope she is right; I fear that her wish can at best change the balance of social power relations but can not do enough to human nature to eliminate sexual abuse.

The problem of incest is complex and the solutions to it will need to be. *Father-Daughter Incest* is a start at presenting great amounts of information to a wide audience. It can be understood by a lay reader and it has a good deal to offer both the theoretically interested and the working field professional.

For the physician, this book will raise consciousness on an important public health problem. It will also raise potentially disturbing questions about his/her lifestyle, relations with chil-

dren, and relations with patients of the opposite gender.

I liked the book and learned from it. I wished there were fewer strident statements that put me—a feminist sympathizer—off, and certainly are insulting to our male colleagues: for example, "Once the male therapist has sufficiently worked through his tendency to identify with the offender, he may be in a position to identify with the victim. He then experiences the same set of reactions found in female therapists."

I wonder if such exaggerations may represent the author's identification with the offender as she launches a violent attack on the incest problem. I hope the means do not undermine the goals. □

CAPSULES

A WOMAN IN RESIDENCE, by Michelle Harrison, Random House, N.Y., 1982.

A Woman In Residence is an uneven, angry, and at times riveting chronicle of author Michelle Harrison's OB-GYN residency at "Doctors Hospital" (the Beth Israel). A 35-year-old family physician with experience attending home births, Harrison found her professional and moral integrity so compromised in OB-GYN that she left the program after seven months.

Written in journal form, the book includes operating room scenes, graphic descriptions of gynecological procedures, memories of home births, and bits of Harrison's domestic life as a single mother. She presents throughout a disturbing view of hospital obstetrics—including high Caesarean, episiotomy and infection rates, and the depersonalizing influence of technology—highly colored by her own reactions: "Every time I begin to plot a woman's labor curve," she writes toward the end, "I feel that I am signing a death warrant."

The strongest element to emerge out of the resulting mixture of material is a self-portrait of a physician in crisis.

— LWD



David M. Bray

New Dean for Management

This summer marks the first changing of the guard among the principal deans of Harvard Medical School since Dean Tosteson reorganized the administration of the school five years ago. Mitchell Adams, Dean for Finance and Business since 1978, has accepted a new post as Vice Chancellor for Administration and Finance at the University of Massachusetts Medical School. His successor, as of September, is David M. Bray, whose new HMS title is Dean for Management and Administration.

Bray leaves a dual position as Executive Director of Hospitals and Clinics, and Associate Vice President for Administration, of the University of Chicago Medical Center. His responsibilities there included direction and management of the center's principal hospital and more than eighty diverse ambulatory care programs. He was also the chief financial officer for the center, which houses the Pritzker

School of Medicine.

Prior to his position in Chicago, Bray was Deputy Associate Director of the U.S. Office of Management and Budget, responsible for that office's functions in the administration of budgets for the Departments of Commerce, Treasury, Transportation and Justice, and roughly fifty independent agencies. His educational background includes studies at Oxford University in economics, public finance, and international economics, and graduate work in economics at the University of Maryland.

Bray's new duties will encompass the financial operation of HMS, including institutional and area planning, physical plant and security, and business relations with affiliated hospitals. One of his main concerns is the "shrinking of public financing for the teaching and training mission of the medical school," and he intends to help the institution "devise alternative strategies for financing important projects." In particular, he says, he wants "to help the faculty get on with what they want to do."

In announcing Bray's appointment, Dean Tosteson noted that "with the increasing financial pressure on all educational institutions, and the growing complexity of the management of such a large and diverse institution as the Harvard Medical School, we are fortunate to have in Mr. Bray someone with extensive experience in government, medical education, and hospital administration."

The Dean also praised Mitchell Adams "for all that he has done to improve the quality of financial and administrative services to the Faculty of Medicine. We have all appreciated his zest for work, his devotion to the broad span of tasks for which he has been responsible, and his loyalty to the school."

Potter To Head Neurobiology Department

David D. Potter, an electrophysiologist and pioneer researcher of the ways in which cells transmit information to each other, has been named head of the Department of Neurobiology. A member of the core group of that department since its inception in 1967, Potter explains that one of its original purposes was the encouragement of long-term collaborations, often by people in different fields—such as biochemistry, electronmicroscopy, and electrophysiology. Such joint efforts, he finds, have "made it possible to attack problems a single individual wouldn't have the capability or energy for."

In his new post Potter intends to continue this style of operation. His own career has involved several collaborative efforts over a span of more than 25 years. Working in the London



David D. Potter

laboratory of Bernard Katz in the late 1950's, he and Edwin Furshpan were the first to describe and analyze electrical (as opposed to chemically induced) synaptic transmission; and with Stephen Kuffler and Edward Kravitz he discovered the existence of low-resistance junctions between cells not generating electrical signals.

During the past decade Potter and Furshpan have succeeded in identifying the transmitters secreted by nerve cells to control the behavior of target cells. They are now studying the question of how the choice of transmitter is controlled.

As head of the Neurobiology Department, Potter replaces Torsten N. Wiesel—who shared a Nobel prize this year with David Hubel for their work on information processing in the visual system. Wiesel will establish a laboratory at Rockefeller University next year, where he will pursue his studies in central nervous system physiology.

Haber Named M.D.-Ph.D. Program Director

Cardiologist Edgar Haber, whose research has led to landmark developments in controlling cardiovascular disease, has been appointed Program Director of the M.D.-Ph.D. Program. Developed to narrow "the gulf of knowledge and understanding that increasingly separates scientists from colleagues in the medical profession," the program combines intensive scientific training with the medical school experience.

Haber, Professor of Medicine and Chief of the Cardiac Unit at Massachusetts General Hospital, has been affiliated with Harvard and the MGH for almost 25 years. He has developed a center of research on ischemic heart disease, and spearheaded investigation of the treatment of cardiovascular disease with antibodies. In his new position, Haber currently oversees the work of sixty M.D.-Ph.D. candidates in over fifteen diverse fields, ranging from the biological sciences to electrical engineering and computer science.

Applications to the M.D.-Ph.D. Program (also known as the Medical Scientist Training Program) are accepted only from Harvard Medical and Health Sciences and Technology students, usually during their second or

third year. Their path through the program is highly flexible, and usually takes from six to eight years. The structure of each individual curriculum is determined with the guidance of an advisory network which includes departmental liaison representatives from the faculty, affiliates who have themselves completed joint-degree programs, and program counselors.

Finland Receives Honorary Degree

Returning to the scene of his college graduation, which took place exactly sixty years ago, Maxwell Finland was the recipient of an honorary Doctor of Science degree at Harvard University commencement on June 10. The citation hailed him as "a distinguished and loyal son who... as physician, teacher and scholar has given wisdom, energy and substance to the advancement of clinical medicine." Finland, HMS '26 and the George Richards Minot Professor of Medicine emeritus, is a world authority on the use of antibacterial agents.

The latest in a long line of Finland feats is a 900-page opus entitled, *The Harvard Medical Unit at Boston City Hospital* (volume I). Edited by Finland and published by the Commonwealth Fund of Countway Library, the book features an overview by William B. Castle, a section on the Harvard Medical Services by Charles S. Davidson, autobiographies and biographies of senior staff, and a wealth of photographs. The price of the volume is \$50 (a complimentary copy will be sent to individuals who make contributions of \$100 or more to the Charles S. Davidson Professorship Fund at HMS). Volume II, jointly edited by Finland and Castle, is scheduled for publication in late fall.

New General Director For MGH

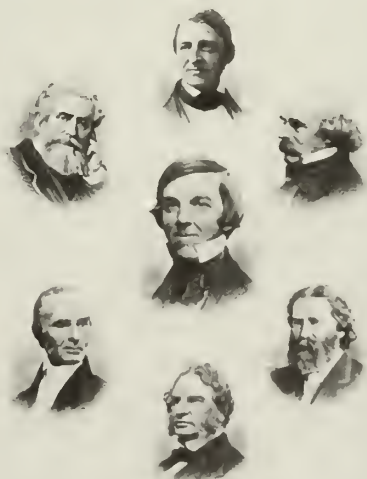
For the first time in twenty years, the Massachusetts General Hospital has appointed a general director from outside the institution. John R. Buchanan, M.D., former president of the Michael Reese Hospital and Medical Center, and Associate Dean of the Pritzker School of Medicine, University of Chicago, assumed the post this past July.



John R. Buchanan

An endocrinologist with broad experience in ambulatory care, Buchanan served as Dean of Cornell University Medical College for seven years before going to Michael Reese in 1976. He was cited by the MGH search committee as having a "combination of outstanding administrative and academic experience."

Buchanan succeeds Charles A. Sanders, who resigned the MGH directorship in 1981.



Note: The correct legend for the portraits of the Saturday Club members which appear on page 26 of the Spring '82 Bulletin is as follows, clockwise from top: Emerson, Hawthorne, Lowell, Longfellow, Whittier, Motley, and Holmes in the center.

Discovering the Heart of Medicine in an African Jungle

by Allan J. Hamilton

I am a part of all that I have met;
Yet all experience is an arch wherethrough
Gleams that untraveled world, whose
margin fades

For ever and for ever when I move.

Ulysses

Alfred Lord Tennyson

I come from a culture—and a profession—that prides itself on its capacity to control the environment, to impose homeostasis where it does not exist, and to restore it where it has been disrupted. But Africa is the very antithesis of homeostasis and stability; it is mutation and flux incarnate. There, change rules supreme.

When I applied for an Albert Schweitzer Fellowship to work for three months at the famous jungle hospital in Lambarene, Gabon, I thought only of the *external* adventure of excitement and romance I envisioned from childhood Tarzan movies. When I got off the plane and saw the modern airport and high-rise hotels of the capital, I was afraid I had arrived too late—that the Africa I sought had already become extinct. But I still had to go over a hundred miles deeper into equatorial jungle to find Lambarene. What I could not know was that the *internal* adventure of being a doctor in Africa would change me forever.

The most striking difference, of course, was the setting in which I now found myself living and practicing. How often had I complained about alternate night-call schedules or sharing on-duty sleeping quarters with two or three other medical students? In Lambarene I shared my room with less predatory but more numerous species—spiders, cockroaches, termites, vampire bats and lizards.

I was on “guard-duty,” as they called it, for one solid week at a stretch. Once, due to staff shortages,

my partner and I had to take call for 21 straight days. We vowed never to complain again about every-other-night call (a pledge which I broke after just a few months back in Boston).

I was impressed by the extent to which families can take excellent care of their relatives, and I came to wonder why, in Western medicine, we have gone to such extraordinary measures to remove the family from involvement in the patient's care.

Instead of electronic beepers, we had runners and shouters to page us. A long-distance “page” required that a nurse or orderly be dispatched to our hut; often this would entail a run of a mile or two. Short distance “pages” were easier. The nurse on duty would lean over the edge of the veranda outside the ward and yell for someone to fetch “Docteur Alain”; the message would then fan out through the hospital compound until it reached my ears. The yell was omnidirectional, and I have often wondered if there are not calls for “Docteur Alain” still inexorably making their way across Africa and on into Asia.

The wards were another revelation to me; Osler, I’m sure, would have felt quite at home there. No plush semi-private rooms or gleaming intensive

care units. In the Schweitzer Hospital we had large open wards with thirty patients on rows of wooden-plank or angle-iron bed frames. The frames are still constructed along the original design established by Dr. Schweitzer: built off the ground to provide enough sleeping space below for the two or three family members charged with the immediate nursing care of the patient.

These relatives are called “guardians,” and it is their responsibility to make sure that the intravenous solutions go in on time, that the patient’s specimens get to the lab, that the dressings get changed, that the patient gets up to X-ray and so on. The guardians are also provided with an open cooking area outside in which to produce meals for themselves and the patient. In short, the family constitutes the primary care nursing staff.

I was impressed by the extent to which families can take excellent care of their relatives, and I came to wonder why, in Western medicine, we have gone to such extraordinary measures to remove the family from involvement in the patient’s care. I know that my own wife would do a better job of feeding me, cleaning me, and dispensing my medications on time than an overworked and underpaid nurse on a busy ward floor; and yet time and again I have seen families rounded up like cattle at the end of visiting hours and stampeded off the floor.

In the intensive care units, families are often allowed in only one member at a time to visit the stricken relative for five minutes out of every half hour, and at a time when the family and the patient often need each other most. If American domestic life epitomizes the breakdown of the nuclear family, then we must assume some responsibility for having faithfully reproduced that phenomenon within the walls of our hospitals.

The guardian system in Gabon is not without its complications, however. At night, when the electric generators have been turned off to conserve precious fuel, it is often a startling experience to make one's way by kerosene lantern to a patient's bedside, stepping gingerly among all the sleeping family members on the corridor floor and occasionally awakening a dog, or discovering chickens roosting for the night where you carefully stored your lumbar puncture sets, or drawing back the sheets to discover two or three small children sleeping contentedly alongside the patient.

Our laboratory facilities were limited and necessarily tailored to the needs of our population. While we had outstanding parasitological and hematological examinations at our disposal, we could not obtain electrolytes. Glucose or the rare liver enzymes were available on an erratic schedule—usually once a week—and cardiac enzymes or bacteriological cultures were distinct impossibilities. Electrocardiograms were not obtainable during most of my stay because the shipment of tracing paper had been languishing on the customs wharf in the capital.

Still, despite the time-honored and notorious arrhythmogenic relationship of potassium, digitalis and diuretics, I treated over a hundred cases of congestive heart failure without daily lytes or dig levels or EKGs. We simply made the families feed the patients ten of the ubiquitous bananas each day, and when the pulse became irregular we backed off the dig a little. This was akin to learning to fly a bush plane after training in a Boeing 747—but it did fly!

Intravenous solutions were similarly primitive: no plastic bags and no disposable angiocatheters. Instead, we made up the solutions each morning and sterilized them in reusable glass bottles. Quality control was something of a problem, and it became second nature to immediately change the intravenous set-up whenever a patient developed a sudden, unexplained fever in the hospital. My differential diagnosis for fever of unknown origin came to include contaminated intravenous fluids and untreated malaria—which accounted for nearly fifty percent of our “in-house” fevers.

Language was another obstacle. French is the national language of Gabon, and I have a fair knowledge of

the language. But many of my patients spoke only native dialects, and then I was faced with the tedious task of translating Fang or Eschira back into French.

It was not only the words themselves which posed a problem but also the way in which words or phrases were used. One woman who had developed a large thyroid tumor and subsequent hyperthyroidism and heart failure complained to me that “a chicken was dancing” in her belly. As I examined her, I asked her about the mass in her neck. “That’s the egg left by the chicken,” she replied. The egg was obvious but the chicken took me some time to unravel: it was her enlarged liver, now tender from venous congestion. As I pressed on its edge,

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she winced, then smiled and said: “Ah, now you’ve got the chicken by the neck.” To quote Winston Churchill, who probably never dreamed his famous words referred to hepatomegaly: “Some chicken...some neck.”

Language, however, had its less comical moments. In Fang, the chief dialect of the region, the word “heart” not only defines the thoracic organ, it also means “courage” and “virility”; and to the primitive Gabonese tribesmen, these two properties are intimately tied to the very essence of their existence. Before I was aware of these multiple meanings I was treating an elderly Fang tribesman for heart failure, and had prescribed one pill of digoxin every day, explaining that, “The pills will make his heart

stronger.” This was dutifully translated back into Fang for the patient. Imagine how shocked and saddened I was when, the next morning, the same man was brought back to me dead. He had gone home, I later found out, and thought to himself: “If one of these pills from the white doctor will make my courage greater, then how much more courageous I will become if I take all of them.” So he swallowed a whole month’s supply of digoxin in one night.

Medications, similarly, had their complications. Unlike American patients who generally abhor needles, and by association any doctor or nurse who brandishes one, Gabonese patients preferred the needle to oral medications: with an injection it was obvious that something was literally being pushed into their bodies before their very eyes. Often patients would plead to have an intravenous line continued, believing it was wholly responsible for their recovery, while their oral medications were only incidental to it. So it happened that many a diabetic patient, having to receive daily injections of insulin, was the envy of the ward. (I should mention that since only about 25 percent of our diabetics had access to a refrigerator in or near their village, we were forced to use oral hyperglycemic agents that were often grossly ineffective.)

One Sunday, a nurse who was relatively new to the ward was giving the patients their injections. In an inexcusable break with ward protocol, she asked the patient if she was supposed to receive an injection that morning. To this, the patient responded “yes, yes” very eagerly, and the nurse dutifully injected the patient with sixty units of insulin. The only problem was that the patient was not a diabetic and subsequently developed a severe hypoglycemic reaction to the shot over the next few hours.

Patients who were illiterate—and more than eighty percent of our population were—presented a second major source of problems with prescribing medications. A Peace Corps volunteer who had worked as an orderly in South America helped me meet this challenge. I simply made diagrams in which each box showed a simple representation of a part of the day: the sun rising, the sun at its zenith at noon, the sun setting, and a crescent-shaped moon going through similar cycles. Under each box I would draw the cor-

rect number of round circles for pills and oblong sausages for capsules. Astrology at work. Who said the movement of the heavenly bodies has no place in medicine?

Probably more than any other facet of my experiences in Gabon, the animistic culture of Fang tribesmen fascinated me; and, as it constituted a fundamental part of many of my patients' lives, it quickly grew to occupy a similar place in my own. Very often a patient who had fallen sick in his village would seek treatment at the hands of the local *fetisheur*. From a volume on native herbs and plants obtained by one of the veteran nurses, I discovered just how encyclopedic is the knowledge of the village shaman with respect to the pharmacopia that grows indigenously in the jungle. In fact, there are over 400 plants in that area of Gabon alone known to have active pharmacological properties—which meant that the village *fetisheur* had a better pharmaceutical stock at his disposal than I did. Many patients were treated entirely by the *fetisheur* and never came to see me for a second opinion; such is the nature of a jungle practice.

On the other hand, like many of my own patients, those of the shaman sometimes suffered the untoward effects of the recommended therapy and would arrive at the hospital to seek help, very often in dreadful states of intoxication: poisoned, stuporous, and hallucinating. Usually it was impossible to know what they had been treated with, since the herbs had names like "the sacred bark" or "the flower of the devil"—and these terms usually varied from village to village. Alas, these patients very often died as we looked on helplessly. On the other hand, I am sure the *fetisheur* saw a fair number of my failures and, on more than one occasion, pondering a package of ampicillin or hydralazine, was equally perplexed with my sorcery.

Indeed, some of my patients saw me as essentially just another kind of witch-doctor. Like my jungle counterpart I had my magical ornaments: my stethoscope, my reflex hammer, and so on. And could I not use my machines to see inside their eyes and look inside their heads? You can, no doubt, imagine the effect on a patient when I listened to his edematous lungs and witnessed his bulging jugular veins and then asked: "Have you not been out of breath walking uphill?"

"Yes, yes, that is true, *mon docteur*."

"And have you also been getting up in the middle of your sleep gasping for air?"

"Yes, yes. Everything you say is true."

"And have you noticed any swelling of your ankles?"

"Oh, yes. It's all true! Everything that you say is true!"

To their eyes I was, indeed, a great sorcerer to be able to divine such things. So great was my power, in fact, that I found patients who had retrieved the disposable otoscope cones and tongue depressors from the wastebasket and were wearing them as charms around their necks to ward off evil spirits. I had to keep all my

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medical instruments locked up lest my sphygmomanometer be appropriated for use as an amulet or my ophthalmoscope as a talisman.

One day an old tribesman was brought to me. Months earlier he had seen a doctor in the nearby Gabonese hospital for earaches, and some eardrops had been prescribed. He had grown gradually deaf over the intervening period. When I peered into his auditory canal with my otoscope, I could not even insert the instrument. Filling both canals completely was a firm, dark plug of hardened wax.

It turned out that the old man had never returned to the hospital, but had just continued putting eardrops into his canals faithfully four times a day. The drops must have been enough to

lubricate a freight train's ballbearings, for the oil hardened and both ears became firmly blocked. Each morning for three days I spent ten or fifteen minutes with an ear-syringe and cotton-tipped strands of bamboo working these concretions free from his ears. On the third day, a large plug the size of a pencil eraser fell free from the canal. As I stared in disbelief at the retrieved fossil in my hand, the patient leaped off the bench, then started hugging me and shouting: "Oh, sweet Jesus! Sweet Jesus! I can hear again! I can hear again!" I quickly cleaned out his other ear and sent him on his way home.

The witnessing of "the miracle" was not without its effect on the other patients and their families. That afternoon I arrived at the outpatient clinic to find nearly 200 patients waiting to see me for similarly dramatic cures. Over the next few weeks, I encountered a seemingly unending line of paraplegics, blind patients, and hopeless invalids. One unfortunate family brought me their dead son in the hope that I could bring him back to life.

There is something important and special which links all these anecdotes—a common thread of humanity. In Gabon I found that medicine is not a collection of facts to be presented on rounds or a statistical assortment of data to be multiplied, divided and manipulated until one has arrived at a diagnosis and a plan of therapy. It is a story of human beings brought together by need and by pain. It is this sense of, as Dr. Schweitzer put it, "the brotherhood of suffering" that I discovered in Africa.

I remember being asked by Dr. Cheever during my admissions interview at HMS why I wanted to become a doctor. (We have all been asked the same question and we have all felt that same twinge of embarrassment when we idealistically answered, "Because I like to help people.") Dr. Cheever paused for a moment and then leaned over and said: "Taking care of people is the *only* good reason to become a doctor." In Africa I discovered the answer has not changed one bit. □

Allan J. Hamilton '82 has begun a surgical residency at the Massachusetts General Hospital. This article was adapted from a speech presented to the Harvard Medical Alumni Council in January, 1982.

A Bicentennial Trilogy

Introduction

Alumnae, Alumni and Guests: On the wall at your left is the inexorable "time machine" that only our speakers can turn backward for us. On your right Walter Bradford Cannon, Professor of Physiology in the first half of this century, looks benignly upon us. His aphorism, appropriate to an alumni gathering, was, "Cast your bread upon the waters and it will come back to you as buttered toast."

You and I are about to enjoy a special feature of the Bicentennial Year. Indeed this "happening" is the essence of the anniversary that we celebrate during this Alumni Week. As you can see from the program, distinguished speakers will discuss aspects of the history of the Harvard Medical School as divided into three periods of time. Likewise, from his experience over the years at alumni reunions, the late Dr. Howard Sprague concluded that the ages of man are three: Youth, Middle Age, and "My, you are looking well!" So may her returning graduates greet their *alma mater* in her two-hundredth year.

History meaningfully relates the circumstances of the past and, if we will but listen, often provides a better understanding of the present. In the early days of the Medical School the professors sold tickets for their lectures to the students. Today they sell them to the graduates for the scientific symposia. Such is the value of tradition. Yes, what the Medical School is today can be appreciated better by learning, as we shall this morning, whence it came.

Beecher and Altschule, in the preface to their historical volume, *Medicine at Harvard*, used the felicitous metaphor of an oarsman who steers well by watching his wake. But, say they, he must turn around and look if he wants to know where he is heading. *That*, all of us would like to know today.

I shall extend their parable by suggesting that a rower with far to go does well to rest occasionally on his oars. So too, during Harvard medicine's long pull there have been times when, like the House of Lords in *Iolanthe*, "It did nothing in particular, but did it very well." Thus does pause for reflection provide guidance for rapid progress in the right direction.

If the course of days past has not always been smooth, its overall characteristic is surely an exponential rate of achievement in the art and science of medicine—illuminated in this century by occasional Nobel novas. There have also been circular motions of almost astronomical dimension. I now read that the Medical Faculty's proposed revision of

the fourth-year clinical curriculum will provide "at least minimal exposure to all the major disciplines in medicine." Reasonable enough, surely, and interesting to me as sounding very much like the plan of instruction for my final clinical year—more than six decades ago.

But there is a difference, because now, with the ever-increasing amount to be learned, the curricular geometry is not that of a circle but rather the rising coil of a helix. Some might see in this a symbolism of the serpent in the Garden of Eden. Dr. David Rogers, a former dean of medicine at Johns Hopkins, finds that American medical students of today are not as happy in their work as in times past. Have some of our teachers forgotten that for medicine the path from man to molecule must always lead back to mankind?

This century milestone of the great past of Harvard medicine that we cherish and expect to continue apace has a new and solemn aspect, because the continued existence of these marble buildings is no longer assured. And yet the vision and determination of the physicians and public health workers of many nations that led to the total elimination of smallpox is surely capable, with the help of the informed citizens of the world, of meeting the awful challenge of nuclear warfare. Today, together with members of the medical and scientific institutions of this community, men and women of Harvard medicine and public health are leading in that vital educational crusade. We can be proud also that the Commissioner of Public Health of Massachusetts has officially recognized the clear and present danger that we face.

A former dean of Harvard's Faculty of Medicine, Dr. George Berry, once told me that the ancient universities of Salerno and Padua became great when medicine was added to their teaching. I think he said that this was because medicine involved a more tangible obligation to society. More recently, such an addiction has come to represent a risk to the financial life of the parent institution, for medical education has gotten very expensive. But the inexhaustible currency that has enriched the mind and spirit of the Harvard Medical School has always been its people: the students who enter, the professors and assistants who teach, and the graduates who carry its imprimatur—especially if they remember that they were once students.

—William B. Castle

The Pilgrim Legacy

by Thomas Boylston Adams

It is a great honor to be asked to address so distinguished a gathering as is here assembled: men and women who have spent years and years in acquiring a special knowledge and skills which must ultimately affect the lives of every creature that lives on this planet. Your work has done more service than that of any other profession to alleviate the cruelty of nature to the human race. As a humble member of that race, I salute you.

I am aware of the honor you do me and I confess my ignorance of your science. I can usefully comment only on some aspects of your art. How you come to be here today, and whither you are going, is important to yourselves, and is crucial to all of us who are born into this world, and must endure it, or enjoy it, as your knowledge and skill, and the wisdom of all of us, or the lack of it, allows or directs.

In seeking for the particular origins of the Harvard Medical School, as opposed to any other medical school—older or younger, more or less famous—we should visit first the low countries of Europe, that part of them now known as Holland, and there the ancient walled city of Leyden.

This city of Leyden, in the sixteenth century, endured a terrible siege by the armies of Philip of Spain. Its heroic resistance was absolutely necessary to save the liberty of the rising Dutch Republic. So when the dikes were cut, and at last tide and wind served, and the half drowned Spaniards retreated and mutinied, the great William of Orange, called the Silent, pondered how he could sufficiently reward the brave citizens. He decided to give them a university. It is perhaps best known to you as the place where Boerhaave lived and worked and reformed the teaching of medicine.

It has an even wider importance. Attracted by the university, and by the tolerant laws which governed the expression of diverse opinion in the Netherlands, various sects of non-conformist English people flocked there in the late 1500's. One group, led by John Robinson, settled in the shadow of the Peterskirk. You can still see the house where he lived and taught. Some of these people came to New England in 1620 and settled at Plymouth. It was hard to leave the comforts of civilization, harder still to leave relatives and friends, "but they knew they were pilgrims, and lift up their eyes to the heavens, their dearest country and quieted their spirits."

That name has stuck. Pilgrims they were, and pilgrims we still are, who care to heed the advice John Robinson gave at the time of parting. Robinson was obliged to stay behind "with the weaker members." What he said was this. He spoke in theoretical terms, but they translate readily into terms



Joseph Warren (courtesy U.S. Department of the Interior, National Park Service, Adams Historic Site, Quincy, MA)

medical, appropriate to the twentieth or any later century:

Be careful what you accept for truth. When you are perfectly sure you know the answer, compare with others. The trouble with the Lutherans is they cannot be drawn to go beyond what Luther saw. As for the Calvinists, they stick where he left them. I charge you before God and His blessed angels, to follow me no further than I follow Christ, and if God shall reveal anything to you by any other instrument of His, be as ready to receive it as ever you were to receive any truth by my ministry. For I am very confident the Lord hath more truth and light to break out of His holy word.

An interesting bit of truth and light did break out, not very long after. You can find in a letter of instructions sent back to England in December 1621 advice on how to survive the long sea voyage: "Bring juice of lemons, and take it fasting. It is of good use." The British navy caught on

The machinery of revolution interfered with formal education. At Harvard the students paid less and less attention to their studies. They took an oath to drink no British tea, to drink only rum instead.

something more than a century later. The American merchant marine was still horribly plagued with scurvy in the 1840's, as Dana vividly describes in *Two Years Before the Mast*.

The habit of inquiry arrived on the *Mayflower*. William Bradford, who soon became governor at Plymouth, a job he was to hold most of his life, observed that the "plague" which killed Indians did not attack white men, even though they lay close in the same hut. His admired friend and mentor, William Brewster, lived to a great age, "though he drunk nothing but water for many years together."

In a more serious matter, a psychological one, the Old Colony of Plymouth behaved with a singular restraint. Towards the end of the seventeenth century, when the witchcraft delusion was terrifying Salem and the north shore of the Bay, a trial was opened in Scituate. One woman accused another of witchcraft, of threatening her in the shape of a bear. "What manner of tail did the bear have?" inquired the magistrate. "I could not tell, your honor. Its head was towards me." The court found for the defendant and ordered a fine and whipping for the accuser.

Plymouth hanged neither Quakers nor witches. It lay somewhat to the left of Boston, to the right of Rhode Island, where Roger Williams preached total toleration. Into this environment, Congregational in religion, therefore independent minded and incipiently democratic, British Colonial in manners, customs and government, were born, in the first third of the eighteenth century, two farmer's sons destined to take an important part in events that would change the shape of the world to come. John Adams was born in Braintree in 1735, Joseph Warren in Roxbury in 1741.

There is one surest way for children of low income to rise in the world. It is to acquire a superior basic education. On this can be built a professional competence. Such education in the 1700's meant Harvard College, although it was possible, by extraordinary diligence, to acquire it by home reading. Latin, Greek and mathematics opened doors. Entrance into only one profession, the ministry, depended on further years at "the College." All other professions were learned by the apprentice system, whether sailing a ship or setting a leg.

Adams chose the law, Warren medicine, after the essential years at Harvard. And even as they were getting their start in life the British Empire was emerging as the greatest in the world, driving France off the American continent and dominating the seas with its navies. Unfortunately it decided to tax its colonies to pay for its success. The first major



University of Leyden, courtesy The Harvard Medical Archives

episode in what would become the American Revolution occurred at the Old State House in 1761, when James Otis argued against the Writs of Assistance, the alleged right of the King's officers to search any house without a warrant. John Adams listened, thrilled. "Otis was a flame of fire. The seeds of patriots and heroes were then and there sown."

The dust and ashes kicked up by this argument also effectively smothered, for the next twenty years, any effort to turn Harvard College into a university. Quaker Pennsylvania, wrapped in brotherly love and calmly concerned with profit and commercial and social ascendancy, founded its medical school in 1765. New York, still dominated by its landed aristocracy of Dutch patroons, could not dream of revolution, preferring the practical alternative of bribing public officials. It founded its medical school in 1768.

The people of Massachusetts, who had been practicing dissent since 1620, had slowly been learning to enjoy it. Before in England, in the reigns of Elizabeth and James, it had been no fun at all—much too dangerous. In Holland it had not been dangerous, but poor fun. In America, after a hard start, the habit of arguing with the neighbors, questioning authority, and resisting encroachments on ancient liberties by the distant British crown, had become a popular sport. John's cousin, Sam Adams, refined this sport of parades, town meetings and occasional riots into high art. This art increased the practice of young Dr. Joseph Warren and his apprentice, Sam Adams, Jr.

There were more broken heads. It brought into sudden prominence John Adams as a useful legal mind to put together the machinery of revolution. But it interfered with formal education. Out at Harvard the students paid less and less attention to their studies. They took an oath to drink no British tea, to drink only rum instead. Plans for a medical school were laid by.

The Boston Massacre of 1770 gave opportunity for Joseph Warren to exercise his talents as an orator. He nearly brought on the Revolution ahead of time. How he kept up his medical practice at all is a wonder. But he did, working night and day. He was the best loved physician in Boston. He was also a major general and President of the Provincial Congress.

The medical profession in Boston became more bitterly divided between patriots and British loyalists. Harvard men might talk of a medical school. They could neither agree on how to found one nor find the time to do it.

The other most prominent physician was Benjamin Church. He was at last proved to be a spy of the British and traitor to the patriot cause. In fact, for a dozen years, the medical profession in Boston had been ever more bitterly divided between patriots and British loyalists. Harvard men might talk of a medical school. They could neither agree on how to found one nor find the time to do it.

The death of Warren at Bunker Hill ended the colonial phase of American history and opened a new epoch. On that 17th of June 1775, Abigail Adams stood on Penn's Hill in Quincy and watched the fires and smoke rising from burning Charlestown and heard the roar of guns. Beside her was her son John Quincy. Warren had been the family physician and had saved John's right forefinger from amputation after a bad fracture. Abigail wrote her husband, in Philadelphia at the Continental Congress, "My bursting heart must find vent at my pen. I have just heard that our dear friend Warren is no more."

Even as this letter was written, a young, ambitious medical student, Benjamin Waterhouse, was arriving in London at the house of his mother's first cousin, the eminent Dr. Fothergill. Waterhouse had left America a few weeks before the Battle of Lexington, on the last ship out of the blockaded port of Boston. From London he went for three years study to Edinburgh. Thence he went to Leyden and matriculated in 1778, entering after his name "Liberæ Republicæ Americanæ Federati civis." This puzzled the authorities, because Holland had not yet recognized the United States. There John Adams found him in 1780. He assisted in placing Adams' sons in the university and acted as their guardian while their father labored at diplomacy.

This diplomacy was effective in obtaining recognition of the United States by the Dutch government, and thereby of a series of loans in gold of millions of guilders that saved the Continental Treasury from collapse. Essential to the success of the diplomacy was a newspaper campaign in Holland in which Adams celebrated an extraordinary phenomenon, the quickening of the intellectual life of a new nation.

"At a time when the English emissaries are filling all Europe with their confident assertions of the distresses of the Americans, the enclosed papers show that both at Philadelphia and Boston the people are so much at ease as to be busily employed in the pursuits of the arts of peace." Then followed accounts of meetings of the American Philosophical Society at Philadelphia and the founding of the American Academy of Arts and Sciences in Boston and excerpts from the new Constitution of Massachusetts, with its powerful emphasis on the duties of magistrates and legislators to promote education—and which also, for the first time on



John Adams at age 31; Portrait by Benjamin Blythe (courtesy The Adams Papers, Massachusetts Historical Society)

record, named Harvard not "the College," but "the University at Cambridge."

Before Adams left The Hague to go to Paris to assist in drafting the definitive peace treaty of 1783 with Britain, he was able to inform his Dutch correspondents of still another interesting fact. Harvard was indeed a university now. It had incorporated, late in 1782, within its structure a graduate school of medicine, in fact the first such school to be established since the birth of the new nation, the United States of America.

I think John Adams may have found peculiar satisfaction in his intimate knowledge of the characters and personalities of two of the three professors appointed to the new school. He was thoroughly acquainted with the active mind, the lively curiosities, the eccentricities of Benjamin Waterhouse. John Warren was the younger brother of his dearest, most admired friend.

Only the weird sisters who met Macbeth and Banquo on the heath could have predicted the triumphs, the troubles, the squabbles, the achievements of the next two-hundred years. Vaccination, anesthesia, the germ theory of disease—even written examinations to test the qualifications of medical students (Dr. Bigelow would argue that half his students could not write!).

But the cauldron was there. The habit of questioning, the value of dissent, were processes of mind that could not easily be shaken off. Always, no matter how closely hidden, there would be more truth and light to break out. □

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Harvard Medical School, 1870-1920

by Kenneth M. Ludmerer

Prior to 1870 Harvard was a proprietary medical school, respected on the standards of the day but not much different than the dozens of other such schools of the time. By 1920, Harvard was a medical school of worldwide importance, offering up-to-date, scientific instruction of the highest quality. Though it has grown and changed in many ways since then, if any of us could visit Harvard Medical School of 1920, we would surely recognize it. It is Harvard's transformation from an inconspicuous nineteenth-century proprietary college into a modern medical school of international eminence that will be the focus of my remarks.

Like all American medical schools of the period, Harvard Medical School in 1870 stood desperately in need of reform. Admission was open to anyone who could pay the fees. Only twenty percent of the students held college degrees, and one faculty member estimated that over half the students could not write. The curriculum consisted of two, four-month terms of lectures, the second identical to the first. There was no gradation of studies, nor were there written examinations. To graduate, a student needed only to pass five of nine perfunctory, five-minute oral examinations at the end of the term. Instruction was almost wholly didactic, relying heavily on the lecture, textbook, and demonstration. In the scientific courses, except for anatomy, students did not engage in laboratory work; in the clinical subjects, students did not participate in patient care.

At this time only a nominal connection existed between the University and the Medical School, which operated on a separate calendar, managed its own financial affairs, and divided the profits among the faculty. For this reason the school strove for large student enrollments and large receipts. The recent book *Medicine at Harvard*, by Beecher and Altschule, has described the Medical School at this time as "a money-making institution, not much better than a diploma mill." Such were the conditions not only at Harvard, but at every American medical school of the period. Henry Jacob Bigelow, the professor of surgery, correctly stated in 1871 that "no successful [medical] school has thought proper to risk large existing classes and large receipts in attempting a more thorough education."

By 1870, however, advances in medical science had rendered obsolete the methods of the proprietary schools. Charles Eliot, President of Harvard University from 1869 to 1909, understood the need to teach medicine in a more rigorous, scientific fashion. Eliot, a chemist, was introduced to chemistry as a Harvard undergraduate working with



Henry J. Bigelow, courtesy The Harvard Medical Archives

Josiah Cooke, and learned the subject by working in the laboratory rather than by simply attending lectures and reading textbooks.

From 1863 to 1865 Eliot studied chemistry abroad, and took advantage of that opportunity to observe closely the French and German systems of medical education. Upon his return to the United States, he was convinced of the importance of science to medicine and of the need to teach scientific principles with laboratories as well as lectures. "The whole system of medical education in this country needs thorough reformation," he wrote in his inaugural report as Harvard president in 1870. He felt that "the ignorance and general incompetency of the average graduate of American Medical Schools, at the time when he receives the degree which turns him loose upon the community, is something horrible to contemplate."

Why, Bigelow asked, should a new president wish to introduce so many changes into a program that had been successful for eighty years? The reason, Eliot answered, was quite simple: "There is a new President."

After assuming the presidency of Harvard, Eliot made reform of the Medical School one of his critically important goals. His plan encompassed three principal areas. First, a series of administrative changes was introduced. The Medical School, which previously had been an independent proprietary school—that is, owned by the faculty and only nominally connected to the University—now became an integral part of the University. The Medical School received the status of a full professional school of the University, began to adhere to the University calendar, and surrendered management of its finances to the University administration.

Second, major changes were made in the curriculum. Before Eliot's arrival, Harvard, like every other American medical school of the time, had offered only two identical sixteen-week courses of lectures. In 1871, the course of instruction was expanded to a three-year program with nine-month terms, and written examinations were introduced into each course. In addition, the subject matter for the first time was ordered in a logical, progressive, structured sequence—the basic sciences preceding pathology and therapeutics, and the scientific courses preceding the clinical work.

Third, and most important, the new curriculum emphasized the laboratory sciences. Previously the only scientific subject taught in a thorough way was anatomy. Now instruction in anatomy was expanded; and rigorous teaching was introduced in chemistry, physiology, microscopic anatomy, and pathology—all of which required significant laboratory work. With these changes, Harvard Medical School entered the modern era.

Eliot's proposals, so reasonable to those of us with the perspective of 1982, were revolutionary at the time and triggered a fierce debate within the medical faculty. The senior members of the faculty, led by the influential Henry Jacob Bigelow and Oliver Wendell Holmes, strenuously opposed the plan. The junior members of the staff, particularly James Clarke White, David Cheever, and Calvin Ellis, strongly supported Eliot's proposals.

With such divisions, the year was one of profound tension and strife. Numerous strained, bitter meetings of the medical faculty were held. Holmes and Bigelow were furious, and their outrage threatened to snuff out the career of the still unestablished Eliot, who had been elected University president by the barest of margins. Nevertheless, through tact, perseverance, conviction, and sheer determination to triumph, Eliot imposed his will. Why, Bigelow asked at one faculty meeting, should a new president wish to introduce so many changes into a program that had been successful for eighty years? The reason, Eliot answered in

an immortalized reply, was quite simple: "There is a new President."

Why should the conservative faction of the faculty have opposed the reforms? A flip answer points to selfish motives, arguing that the senior members did not wish to relinquish receipts or control of the school. Such a reply ignores the important fact that Holmes and Bigelow were magnanimous, not petty, men who had worked long and selflessly for Harvard and for Boston.

An equally glib reply speaks of a "generation gap," asserting that Holmes and Bigelow were too old to appreciate the importance of change. Aside from the fact that this interpretation forgets how instrumental teachers usually are in forming the value system and ethos of their students, it overlooks the fact that Holmes, discoverer of the mode of transmission of puerperal fever, and Bigelow, a participant at the first public demonstration of anesthesia and one of the eminent surgeons of his generation, possessed two of the great minds in nineteenth-century American medicine.

A more satisfactory explanation relates to the way science was perceived by the members of the medical faculty. The senior professors, including Holmes and Bigelow, had taken post-graduate training in France and from their French mentors had learned the skills of astute clinical observation. Like their French teachers, however, they remained skeptical that experimental investigation played any role in medical progress. Medical discovery, they maintained, resulted from the keen observations of workers who could recognize the importance of phenomena they might stumble upon by chance, not from controlled, designed experiments aimed at wresting nature's secrets from her. (Recall that the two greatest scientific figures in nineteenth-century French medicine, Claude Bernard and Louis Pasteur, did not hold positions on a medical faculty.)

The younger members of the Harvard faculty, however, were part of that first wave of American migration to Germany and Austria for post-graduate medical training. This experience had convinced them that basic science was applicable to clinical medicine—that disease phenomena could ultimately be understood in physicochemical terms, and that the mysteries of disease and of therapeutics could be unraveled by experimental manipulation of nature, not just by fortuitous observation alone.

The faculty member most outspoken in this regard was James Clarke White, the strongest supporter of Eliot's proposals. In the 1860's he had already stirred the ire of his senior colleagues by publishing an editorial in the *Boston Medical and Surgical Journal* in which he praised the virtues of scientific medicine that had made Berlin and Vienna the world's "great schools of medicine." Parisian medicine, in contrast, by its neglect of the basic sciences, was in a state of "decadence," living "chiefly on the reputation of its past greatness." In these contrasting views of the relationship of experimental science to medical progress can the rift in the medical faculty over Eliot's proposals be best understood.

The primary consequence of the 1871 reforms was the establishment of much better instruction in the basic sciences. Previously, the only scientific subject taught effectively was anatomy. Now, instruction was added or greatly expanded in chemistry, physiology, and pathology. In addition, in 1871 Henry Pickering Bowditch received a full-time, salaried appointment in physiology. Bowditch, later Dean of the Medical School and the premiere American physiologist of his generation, was the first medical professor

in America to spend his entire time in teaching and research, freed from the necessity of private practice to earn a living. For the first time science was legitimized at Harvard Medical School.

Although science received increased attention in the new curriculum, a much more important change occurred in the way science was taught after 1871. The student's role in the learning process changed from passive observer to active participant. This was accomplished by the introduction of required laboratory instruction for every student in each of the science courses. Previously, the only required laboratory work had been in anatomy, and the school contained only sixteen chemistry desks for 300 students. In 1871, the number of chemistry desks was increased to 100; three large, new laboratories were built for physiologic and microscopic work; and laboratory instruction soon became mandatory in anatomy, physiology, chemistry, and pathological anatomy.

Scientific principles were now to be learned not from lectures or demonstrations alone, but from the student's own experimentation in the laboratory—as Eliot had learned chemistry and as the German medical schools were teaching the sciences to their students. Scientific principles, Eliot contended, were more readily grasped by those who actually experienced them than by those who merely heard about them. This emphasis upon “learning by doing” was by far the most important pedagogic innovation of the 1871 reforms. It constituted a qualitative change in teaching methods that dwarfed in significance the quantitative changes of a longer curriculum, new subjects, and more rigorous standards of admission and grading. Learning by doing was to become the hallmark of the educational changes that later swept American medical schools generally, including the Johns Hopkins Medical School in 1893.

To Eliot and his faculty supporters, there was a further purpose to making the laboratory the primary vehicle of scientific instruction. The empiricism of laboratory training fostered a distrust of traditional explanations and speculative theories—a distrust that was increasingly felt to be justified as the pace of medical discovery grew during the mid-nineteenth century. As Bowditch put it, the laboratory method is “to be regarded as a reaction against the too exclusive use of the so-called didactic method of instruction, as a result of which students, getting their knowledge wholly from lectures and textbooks . . . were thus insensibly led to depend upon authority instead of upon the direct observation of nature.”

Nothing less than a new philosophy of education emerged out of the 1871 reforms. The primary purpose of medical education was now considered to be the cultivation of critical habits of thinking, not the mere memorization of facts, because, with knowledge so rapidly increasing and changing, today's truth might be tomorrow's fallacy. The purpose of medical training was now to foster the student's ability to think critically and rigorously, to solve problems, to acquire new information, to keep up with the changing times. This was best done in the laboratory rather than in the lecture hall. “Contact with the phenomena themselves and not with descriptions of them trains the mind of the student for power by teaching him to observe carefully and reason correctly,” Bowditch wrote.

The reforms of 1871 were significant for another reason: the newly forged link between the Medical School and the University. The post-Civil War years witnessed the birth of



David W. Cheever, courtesy The Harvard Medical Archives

the modern university in America, and Eliot's appointment as president of Harvard coincided closely with the appointments of several other prominent university presidents: Andrew Dickson White at Cornell in 1868; James Burrill Angell at Michigan in 1871; and Daniel Coit Gilman at Johns Hopkins in 1876. These university presidents considered themselves to be *educators*, and they argued that all activities of higher education belonged within the university's jurisprudence. To Eliot, medicine—and every other academic subject—belonged within the province of the new American university. “It is only necessary that every subject should be taught at the university on a higher plane than elsewhere,” he wrote.

Although the thrust of the 1871 reforms at Harvard Medical School concerned the basic-science teaching, significant improvements in clinical teaching also occurred during the Eliot administration. However, these changes occurred later and in a more gradual, evolutionary way. In the late 1870's the obstetrics department began to offer increased clinical training on an optional basis; in 1883 the department made it mandatory that each student conduct at least two deliveries.

Similar changes designed to provide the student greater practical experience came in surgery in 1887 with the appointment of Charles B. Porter as professor, and in medicine in 1892 with the appointment of Reginald H. Fitz. Within individual departments, improvements in instruction also occurred gradually rather than precipitously. Fitz, for example, from the beginning offered much more practical instruction than his predecessor, but over the next decade he continued to expand the amount of clinical teaching in internal medicine wherever he had the opportunity to do so.

The emphasis upon "learning by doing" dwarfed in significance the quantitative changes of a longer curriculum, new subjects, and more rigorous standards of admission and grading.

Coincident with the expansion and improvement of the clinical instruction were other changes. In 1880 the school added an optional fourth year, largely to provide an opportunity for additional clinical instruction in small groups at the various hospitals. In 1892 the fourth year became mandatory. In 1895, in response to the increasing amount of medical knowledge, the faculty introduced the elective system to provide the students more latitude and choice in their studies. With the increasing rigor of both the scientific and clinical training, the faculty observed that the students' performance in medical school correlated with the quality of their preliminary training. Accordingly, in 1900 the faculty made the bachelor's degree a requirement for admission. That requirement had been preceded since 1877 by a rule that students without a degree pass an entrance examination, and by 1900 approximately half the entering students had taken the degree anyway.

The improvements in clinical teaching carried the same thrust as the earlier innovations in scientific instruction. The amount of instruction in the clinical subjects was greatly expanded, but more important, the students became increasingly involved in the learning process. In the late 1870's and 1880's, earlier didactic techniques—lectures, demonstration, ward walks in large groups—were reduced to a supplementary role in the clinical courses. In their place arose a system in which clinical subjects were taught to students in small groups or sections at the bedside, with personalized instruction and close supervision. Students would spend an hour or two a day, three to five days a week, examining patients in the hospital and following the progress of cases under their mentors' care.

The changes in clinical teaching that began in the 1870's and 1880's with the section method culminated in the early 1890's with an attempt to establish the clerkship as the standard method of clinical instruction for fourth-year students. The clerkship, in which students would continuously observe the course of very ill patients, not only allowed students to receive instruction in the hospital but also to become an active part of the hospital machinery.

As clerks, students took their patients' histories, performed physical examinations and laboratory tests, made suggestions regarding therapy, carried out procedures such as catheterization and dressing changes, and followed the daily progress of their patients until discharge. In the surgical courses, they assisted at operations; and in many courses, if their patients died, they helped perform the autopsy. The clerkship thus represented a fundamental advance over the section method of instruction. Whereas in

the basic sciences the transition of the student from passive observer to active participant in the learning process came with the laboratory method of instruction, in the clinical subjects that transition came with the clerkship.

By the early 1890's the Harvard clinical faculty, led by Reginald Fitz in medicine and John Collins Warren in surgery, wished to implement the clerkship as the standard vehicle of clinical instruction for all fourth-year students. Nevertheless, for over twenty years they were unsuccessful. The clerkship, or "house pupil rotation" as it was called at the Massachusetts General Hospital, remained reserved for only a handful of students. For the rest, the section method of teaching and more intensive use of several out-patient dispensaries had to suffice. This is why the famous Flexner Report of 1910 criticized the clinical teaching at Harvard, and those criticisms were justified. It was ironic, as Flexner pointed out, to find in such close proximity to the Medical School so much clinical material that was so poorly utilized for teaching purposes.

The obstacle to implementing the clerkship at this time did not stem from any lack of faculty desire but from the attitude of the school's affiliated hospitals. As late as 1912 both the Boston City Hospital and the Massachusetts General Hospital adamantly refused to permit the routine use of the clerkship on their wards, notwithstanding the vigorous protests of the medical faculty. To understand why, we must remember that the American hospital of the nineteenth century was an entirely different institution from what it became in the twentieth. Throughout most of the 1800's the hospital was a domicile for the sick poor, not an institution for the delivery of effective scientific medical care. In this context, hospital trustees viewed teaching and research as, at most, peripheral functions of hospitals. Students were considered intruders, to be tolerated under rigidly controlled conditions but not to be welcomed.

Earlier in the history of Harvard Medical School, students had to pay additional fees just to be permitted to enter various hospitals for the ward talks, and as late as 1883 they had to pay extra fees to obtain patients for their obstetrics course. Some hospitals even refused to permit students to enter the buildings. A group of Harvard students in 1899 complained: "As students, we have sometimes had serious reason to doubt that the hospital authorities were in sympathy with the cause of medical education, and it has at least been suggested that they regard the students as interlopers, to be disposed of with all possible speed." Such attitudes characterized not just the Boston hospitals but all American hospitals of the period.

As Harvard earlier had solved its problems of science teaching, so too did the school solve its problems of clinical teaching. During the first decade of this century negotiations were being conducted between representatives of the school and of the Peter Bent Brigham Hospital. The result was a new arrangement, based on that between the Johns Hopkins Medical School and Hospital, in which the Brigham agreed to permit the medical school to appoint the hospital staff and to use the wards for teaching and research. Although the hospital opened in 1912, this arrangement with the Medical School had been agreed upon by 1909. (Had Abraham Flexner been cognizant of this, his report on Harvard Medical School might have read differently.)

The Brigham was one of the first hospitals in the United States to be a true teaching hospital, and, as such, it opened its wards to all fourth-year students so they could work as

hospital clerks. Within a few years, as a result of negotiations led by Harvard's new dean, David Edsall, the Massachusetts General Hospital and the Boston City Hospital followed course. Before World War I had ended, to quote John Collins Warren, "the Medical School of Harvard University actually extended into the great teaching hospitals of metropolitan Boston." The clerkship had at last arrived.

One last aspect of the school's development between 1870 and 1920 deserves attention: the enormous growth of its physical plant, and a corresponding growth of its endowment. In 1874, the value of Harvard Medical School's plant at its modest headquarters, then at North Grove Street, was approximately \$100,000; and the school had no surplus funds for investment. By 1883, the school's assets had grown to approximately \$420,000. In 1884 the school moved to a new location on Boylston Street, which in 1900 was conservatively appraised at \$500,000; in 1900 the school's permanent endowment came close to \$1,000,000.

By the end of the first decade of the present century, the school possessed assets that could be matched among American medical schools only by Johns Hopkins. Its new plant on Longwood Avenue, which was opened in 1906, was built at a cost of \$3,000,000, and the school's operating budget for 1908 was \$251,398. This enormous fiscal growth resulted not from student fees, which in the 1870's amounted to \$200 per year, but from private gifts to the school.

Much of the school's financial growth occurred gradually. In the background was the accumulation of wealth in the country. Between 1869 and 1901, the gross national product doubled, and by 1892 over 4,000 Americans had reached the status of millionaire. Also important was an emerging tradition of philanthropy in America—toward "worthy" purposes in general, and toward education in particular. Between 1875 and 1902, higher education in America received \$153,000,000 in endowment gifts. Harvard's drive toward economic security was aided by several wealthy members of the medical faculty who clearly understood the school's need for financial assistance. Upon his death in 1883, Calvin Ellis, who had served as dean for the previous ten years, left the school his estate of \$400,000. In 1889 Henry F. Sears, a young faculty member and a recent Harvard Medical graduate, donated \$35,000 to construct a much needed laboratory building.

The large part of the school's endowment, however, was raised in two critical fund-raising drives. The first, initiated in 1874, collected \$200,000 to permit the erection of a modern complex for improved instruction in the laboratory sciences. The second, begun in 1901, raised \$3,000,000 to enable construction of the school's present campus on Longwood Avenue. These fund-raising drives were essential to the emergence of Harvard as a modern medical school, making possible substantial improvements in both scientific and clinical teaching, as well as the support of research.

Both campaigns were initiated by the medical faculty itself. In 1874 and 1901, the school determined its needs and launched fund-raising drives to meet them. The leaders of both campaigns were Bowditch and Warren, who approached this task with missionary fervor. As entrepreneurs, they served Harvard as William Welch later served Johns Hopkins and the country's medical schools as a whole. Their persuasiveness, tact, and perseverance accounted for much of the school's success in raising money. Most donors to both campaigns, large and small, were passive, responding to the

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solicitations of the professors. The efforts of Bowditch and Warren in both drives greatly benefited from changes in the public's perception of the school's goals and directions. The 1874 campaign profited from the school's new image as a genuine educational institution rather than a business; and the 1901 campaign was facilitated by public recognition of the school's research role.

Harvard's success in raising funds for its Medical School during the Eliot administration forces a revision of the standard interpretation of the development of medical philanthropy in America. It is customary to regard Johns Hopkins as an anomaly and to view World War I, with the growth of the foundations, as the beginning of the era of medical philanthropy in the United States. Clearly, however, as the case of Harvard demonstrates, a willingness to donate to medical schools existed a full generation earlier than usually supposed. The sum of \$200,000 was no small amount in 1874, nor was \$3,000,000 in 1901. It is true that Harvard Medical School was distinctly unusual in its ability to raise large sums at that time. Nevertheless, as Harvard demonstrated, donations to support medical education and research could be procured if the circumstances were right.

All of these events, it should be noted, were important not only to the development of Harvard Medical School but to American medical education generally. By the 1890's the intellectual revolution in American medical education had been completed. Dedicated faculties across the country understood the need to teach medicine in a more intensive, scientific way and attempted to do so. Virtually everywhere, however, progress was severely hindered because schools lacked the teaching hospitals and financial resources necessary to implement their ideals adequately. What was lacking in American medical schools at the time of the Flexner Report in 1910 was the way, not the will, to reform. Harvard between 1870 and 1920 showed its fellow medical schools how to find the way. □

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Harvard University and Medical Education in the Twentieth Century

by Gert H. Brieger

I bring you greetings from the University of California and the oldest medical school on the west coast. It is but a youngster when compared to this venerable institution now on the verge of beginning its third century. I believe it is true, as William H. Welch of Johns Hopkins noted when he helped dedicate these buildings in 1906, that this "is an occasion for rejoicing, not to Harvard University alone, but to all in this country and elsewhere interested in the progress of medical education and medical science."

President Eliot was fond of saying, "The first step towards obtaining an endowment is to deserve one." The same, of course, holds true for a reputation. You have maintained such a preeminent place among the world's medical schools precisely because you have deserved it. A school may be judged by its students, its graduates, and its faculty. All have long been of very high quality here at Harvard. Your position as an integral part of Harvard University and the upholding of those academic traditions have also been important factors in your continuing success.

Your Bicentennial Committee asked me to speak about Harvard Medical School and its affiliated hospitals between 1920 and 1982. There is so much to celebrate and such a vast story to be told, that it is far too great a task for one historian given only a few minutes or a few pages. So much has happened in the first three quarters of this century that it staggers the imagination.

As I have been working on a new edition of Fielding H. Garrison's textbook of medical history, I have read much about the exciting developments of diagnostic techniques, new surgical procedures, and the new understanding of basic physiological and biochemical mechanisms that have emanated from your clinics and laboratories. To name some of the Harvard contributors to medicine of this century would surely be to neglect others equally deserving. I wish instead to focus on the theme of social medicine.

Somewhat to my surprise, I confess, amidst the story of outstanding clinical and scientific work at Harvard, there appears a very definite thread of social medicine. An appreciation for the broader aspects of behavioral and community medicine is to be expected from a school with strong departments of psychiatry and the neurosciences, and a school of public health next door. In all this, however, there seems to have been much more than mere chance. The emphasis on knowledge of social structure as well as on cell structure is pervasive in Harvard's history. It is truly the tale of a university, not merely of a medical school.

The story actually has a nineteenth-century beginning.

In his Report for 1882-1883, President Eliot wrote, "The University has no professorship of public health, or preventive medicine, a modern subject of great importance which can be properly dealt with only through an endowed professorship." Not until 1897 did hygiene become a required course; and the endowed professorship did not become reality until 1909, when the school established one of the country's first full-time chairs in preventive medicine.

At the 1906 dedication, Welch spoke on the "Unity of the Medical Sciences," and Eliot on "The Future of Medicine." It was a period of intense excitement in medical science, and the future of this school, and of medicine as a whole, was perceived as very bright. The stress on better science in medical education, to be institutionalized by Flexner and many others in the succeeding years, was already much in evidence. Yet Eliot spoke of ordinary physicians and average patients, of individuals as well as populations.

In a paragraph worthy of the 1970's, Eliot proclaimed, "The profession must recognize that health is eminently a social product. . . . The medicine of the future has therefore to deal much more extensively than in the past with preventive medicine, or in other words, with the causes of disease as it attacks society, the community, or the state, rather than the individual." Jean Curran, a public health historian and 1921 HMS graduate, remembers those days as a time when "the concept of the essential unity of curative, preventive, and hygienic medicine was deeply instilled into the medical and public health students."

Much of the spirit noted by Curran may be ascribed to David Linn Edsall, one of this country's most productive clinical scientists around the turn of the century. Edsall came to the Massachusetts General Hospital as Jackson Professor of Medicine in 1912. In 1918 he became Dean of HMS, and with the founding of the School of Public Health in 1922, held the joint deanship until 1935. In his splendid biography of Edsall, Joseph Aub points out that the dean, while solidly established as a scientific investigator, had broad visions of the potential scope of good medical education. These included the notion that preventive medicine should concern itself not only with the control of infectious diseases, but also with the factors of heredity, environment, nutrition, and occupational diseases.

Three years prior to Edsall's retirement in 1935, two committees on the status of medicine in America issued final reports. In these remarkable documents, now half a century old, we may clearly see the state of medical education and medical practice in 1932. Both committees began their



David L. Edsall, courtesy The Harvard Medical Archives

study in the prosperity of the mid-1920's and ended their work amidst the sobering realities of the depression.

The results of one, the Commission on Medical Education, are of immediate concern to our theme of social medicine. Chaired by President Lowell, the commission was heavily Harvard influenced. Its seventeen members included David Edsall, Hans Zinsser, and Hugh Cabot. Willard Rappleye, an HMS graduate and later Dean at Columbia, wrote the 400-page final report.

From its seven-year study the Commission concluded that prevention is not a subject merely to be taught by special courses; it is a spirit, an attitude by which the entire medical curriculum must be permeated. Many of the points raised—such as the maldistribution of physicians, the rapid pace of medical developments, the problems of narrow specialization, and the lack of attention to the social and economic aspects of medicine—have been repeated countless times in the past fifty years.

The weaknesses of medical education in 1932, it is depressing to report, were also all too similar to those still being reported by our students today. Gentle vengeance indeed! Criticisms included excessive dependence upon lectures, memorization of facts rather than learning general principles, and insufficient emphasis on problem solving. The commission did see some signs of improvement: Pre-medical education was slowly evolving, and more attention was gradually being paid to the study of the patient as a whole.

Another publishing event of 1932 was the appearance of Walter Cannon's *The Wisdom of the Body*, a provocative description of the important physiological concept of homeostasis. Cannon had introduced the term in an article for *Physiological Reviews* in 1929 to define the coordinated physiological processes by which organisms maintain their steady states.

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Cannon's Harvard colleague Lawrence J. Henderson had already written *Fitness of the Environment* (1913) and *The Order of Nature* (1917), so that the appearance of an educated reading public for *The Wisdom of the Body* came as no great surprise. What was of special note, and of particular interest to the theme of social medicine, was Cannon's epilogue to the book. To a straightforward physiological treatise, Cannon appended a chapter on the "Relations of Biological and Social Homeostasis."

"Are there no general principles of stabilization?" he asked. "May not the devices developed in the animal organism for preserving steady states illustrate methods which are used, or which could be used, elsewhere? Would not a comparative study of stabilizing processes be suggestive? Might it not be useful to examine other forms of organization—industrial, domestic or social—in the light of the organization of the body?"

Some might fear that social stabilization would lead to dull monotony. Cannon did not, however, believing that with homeostasis, the essential functions would be left to a regulated state so that other functions would be freed. "Bodily homeostasis," Cannon wrote, "as we have learned, results in liberating those functions of the nervous system that adapt the organism to new situations, from the necessity of paying routine attention to the management of the details of bare existence. . . . With homeostatic devices, however, that keep essential bodily processes steady, we as individuals are free from such slavery—free to enter into agreeable relations with our fellows, free to enjoy beautiful things, to explore and understand the wonders of the world about us, to develop new ideas and interests, and to work and play, untrammelled by anxieties concerning our bodily affairs." In other words, homeostasis is the physiological as well as the social mechanism which allows for adventure and achievement.

Lawrence J. Henderson is one of the best examples of the strong link between the medical school and the university. He taught, at various times, on both sides of the river, and provided another articulate voice for the broadest possible aspects of medicine. Henderson, of course, was the basic scientist par excellence. Since early in the century all students of acid-base balance have learned about the Henderson-Hasselbalch equation. In 1928 he published his exhaustive treatise, *Blood: A Study in General Physiology*.

It was not long until Henderson began to see that the physician and the patient constituted a social system. Indeed, in 1935 he wrote "The Physician and Patient as a Social System" for the *New England Journal of Medicine*, in which he wondered why the sciences of human communication were not as basic to medicine as anatomy, biochemistry, and physiology. Yet it is the latter that have come, in our day, to be known as the basic sciences, along with pharmacology and microbiology. As late as the mid-1920's they were still



Lawrence J. Henderson, courtesy The Harvard Medical Archives

referred to as the preclinical sciences, a far less arrogant term, it seems to me.

Henderson said the next year to the Association of American Physicians that it was not possible to understand the patient without knowledge of the environment: "... it is the business of the physician never to forget these social factors; to acquire skill in the diagnosis of social conditions and in the recognition of the social elements in the etiology of disease." Unusual words from a biochemist.

As important as Henderson believed the social sciences to be for medicine, he was fully aware, as he noted in 1940, that "the social sciences will become more fruitful when in certain ways the thought and procedures of social scientists conform more closely to those of medical scientists." Henderson's death, just forty years ago, has left a void that has not been easily filled.

At a meeting in honor of Dean Edsall's retirement in 1935, Henderson spoke about the "Relation of Medicine to the Fundamental Sciences." His first paragraph summarizes much of what I have been trying to say about Harvard University, the Harvard Medical School, and the rich tradition of social medicine:

The practice, teaching and science of medicine have never been isolated from the other affairs of men, but have modified them and been modified by them. My subject is this interaction, for I have been commanded to speak of it as it exists now and especially as it exists here at Harvard at the end of Dr. Edsall's administration under the influence of changes that he has directed. These changes are the consequences of forces and tendencies that Dr. Edsall has controlled and utilized. These changes are great, the forces strong, the tendencies by no means superficial. All three are manifestations of important intellectual and social processes which concern the university as a whole as well as its parts, and which involve both private affairs and the state itself.

I would like to end this Bicentennial tribute with one more example of the wide vision of Harvard medicine: Surgery has emerged in the twentieth century as an increasingly successful form of therapy. Surgeons have become biologists, and in this transformation Harvard has played a leading role. Dr. Eugene DuBois of Cornell noted at the time of Edsall's retirement, "Surgery is taking a leading place, as, for example, at Harvard, where its contributions to physiology have been more important than those of most departments of physiology."

The surgical literature is also rich in discussions of medical education. In my research for a book on the history of premedical education, I encountered a remarkable report on undergraduate medical education by Oliver Cope that appeared in the American Surgical Association's *Transactions* in 1950. This report's clear vision of the needs of medical education so impressed me that I would like to say a few words about it here.

In the late 1940's the American Surgical Association sensed the necessity for careful scrutiny of the selection of medical students and their education. Such scrutiny had been neglected for some years in favor of repeated discussions about post-graduate surgical training, and the committee believed that revision was needed in medical education. That change, Dr. Cope and his colleagues wrote in 1950, should be a more flexible curriculum—one which would inculcate appreciation for the concepts of psychiatry, a sense of community responsibility, and preventive medicine. Edsall, Cannon, and Henderson would have been pleased to read the following from this report by some of America's most eminent surgeons:

Medicine deals with the human being; the primary objective of medical education is therefore the appreciation of man, his behavior and environment. This appreciation includes man's genesis, growth and maturity, his nature and the effects upon him of the buffeting which he receives from both sides. In addition to physical trauma, infectious disease, and the wearing of age, this buffeting includes the opposing drives of emotional forces, his needs and dislikes and the influence of social custom.

Cope wrote that students need to develop a sense of social responsibility and understanding of their own emotional growth and needs. It has taken virtually a whole generation for sentiments such as these to become a commonly accepted concern. The surgeons in 1950 also stressed points already made by Lowell's commission in 1932: Too much emphasis was on teaching facts, not enough on the teaching of concepts—the latter being much the more difficult for both students and teachers; and the cultivation of a sense of social responsibility should be taught by precept, not by lectures.

The medical curriculum, the surgeons believed in 1950, was overcrowded. Students had too little time to reflect about what they were being taught. A distinction was needed between true education and mere training. The immediate post-war era was also a time when the preclinical sciences were increasingly taught by teachers with non-medical and non-clinical training.

"By withdrawing from the teaching in the first year and a half," the report noted, "the clinician has inadvertently relinquished to the laboratory scientist the responsibility for teaching the student during his most formative period. This situation was no barrier to sound education so long as the laboratory scientists were teachers well-founded in the prob-



Oliver Cope circa 1950

lems facing the clinician."

I have said enough, I hope, to indicate that in 1950, as in 1932, and indeed in the Flexner Report of 1910, many of the problems addressed by curriculum committees in the 1970's and complained about by our students all over this country were quite clearly spelled out. We know the questions. Do we, in the 1980's, want to face the answers? Your dean has on several occasions written perceptively about the needs and opportunities in medical education. How much can he or any dean be expected to do to overcome the double burden of a weighty system and a weighty tradition? As I have tried to indicate, science is not the only component of that tradition.

I have left out more than I could include. I have said nothing, for instance, of Richard Cabot and of Ida Cannon and the beginnings of medical social work, of Alice Hamilton and of Edsall's role in establishing industrial medicine as a field of study in this country. I have said nothing of the fascinating work carried on by Henderson and his collaborators in the Harvard Fatigue Laboratory established in 1927 in conjunction with the School of Business, nor of the renowned Department of Preventive Medicine which continues this rich tradition today.

Frederick Lewis Allen has called the period between 1900 and 1950 "The Big Change." Medicine also transformed itself during that time, most certainly affected by changes in American society. During the past two decades, we have all been a part of several social revolutions which have also profoundly affected the place of medicine in our society.

A half-century ago the Committee on the Costs of Medical Care and the Commission on Medical Education clearly defined problems of organization, financing, and administration of medical care. Today we call it health care. The name matters not. The fine tradition of social medicine

To denigrate the value of science in medicine by claiming that non-scientific approaches to the medical task are more "humanistic" is to seriously misread the past.

so long and carefully nurtured by Harvard University needs continuing support, as does the work in biomedical science.

In my struggle to comprehend the recent history of medicine, I have become aware of several paradoxes. There is no doubt that science has contributed to medical practice a greater understanding of physiological and pathological processes, thus allowing physicians greater certainty and assurance with which to make diagnostic and therapeutic decisions. And it seems puzzling that just as medicine has become increasingly dependent upon science, the trend has been to reduce its emphasis in the medical school curriculum.

Since the early days of this century we have agreed that students learn more efficiently from an active rather than a passive process. Yet we persist in the latter. Flexner wrote in 1910: "The student no longer merely watches, listens, memorizes; he does. His own activities in the laboratory and in the clinic are the main factors in his instruction and discipline." Read this to students in the first two years of most medical schools today and the reaction will be laughter, if not anger.

It is also ironic that in Flexner's day a main complaint was that teachers of the preclinical sciences were too often poorly qualified in science. Most of them were mere practitioners of medicine. Now we hear that too many medical school faculty members have little interest or understanding of the practitioner's needs.

Some have charged that science has been so over-emphasized that we have depersonalized or even dehumanized medicine. Does science deserve the blame, or does it merely serve as a convenient scapegoat? This, too, is not a recent criticism. Francis Peabody wrote about it in his famous address of 1927. He stressed then that the art of medicine and its science are complementary, not antagonistic.

To denigrate the value of science in medicine by claiming that non-scientific approaches to the medical task are more "humanistic" is seriously to misread the past, especially the rich tradition of Harvard Medical School. It also shows, in my opinion, very little understanding of the future. John Stuart Mill wrote in 1831, in a series of essays titled "The Spirit of An Age," about the difficulties of writing contemporary history and of determining just when a period of transition has begun. His warning of 150 years ago is still appropriate: "The best guide is not he who, when people are in the right path, merely praises it, but he who shows them the pitfalls and precipices by which it is endangered."

I trust and hope that your third century will be as rich and full of accomplishments as the first two. □

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Recipe for a well-rounded Alumni Week to kick off HMS's 200th birthday:

Present an ample portion of retrospective views of medical education, the history of Harvard Medical School, and scientific symposia addressing current medical issues. Lighten with a panel discussion between figures from the past (Richard Warren '34 as John Warren, Lamar Soutter '35 as Oliver Wendell Holmes, Howard Ulfelder '36 as Henry Bigelow, Francis Moore '39 as Edward Churchill, and Claude Welch '32 as narrator).

Season with a ceremony to open the Bicentennial year. Spice liberally with social and cultural events, in-

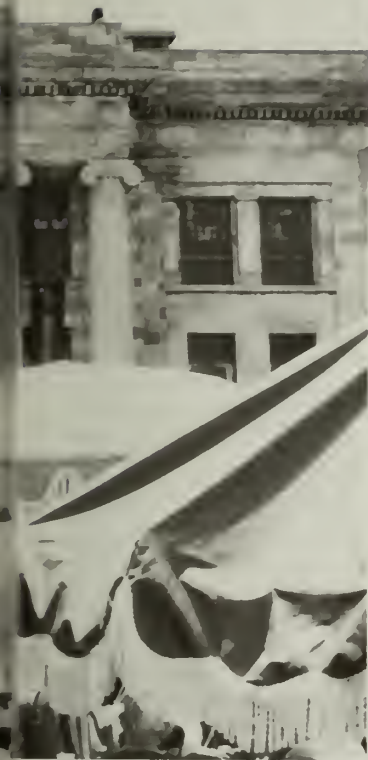
cluding a reception and dinner at the Museum of Science sponsored by the Class of '32 (featuring reminiscences by Lewis Thomas '37 and a traffic-halting fireworks display); a garden party; and an HMS Night at the Pops (featuring pianist Richard Kogan '82).

Add the usual portion of Alumni and Class Day activities, including speeches, luncheons, and reunions.

Make sure to hold these events during the only four days in a very soggy spring when the clouds part to allow brilliantly clear skies.

Last but not least, chronicle all of the above ingredients with photographs for the pages of the *Alumni Bulletin* (Alumni Week, pp. 26-29; Class Day, pp. 46-49). □

The Rites of



LAURIE COPLAND



LAURIE COPLAND

JERRY BERNDT



JERRY BERNDT

Spring '82

JERRY BERNDT



LAURIE COWLAND



MIMI THOMPSON BREED



MIMI THOMPSON BREED



JERRY BERNDT



JERRY BERNDT



JERRY BERNDT



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JERRY BERNDT



Asklepios* and Zeus

by Victor W. Sidel

It is a privilege to have been invited to speak here today, but this opportunity led to some hard choices. One possibility was to concentrate on the Bronx; present data on the differences in health status and health services between the North and the South Bronx; and tell you in detail of the decimation of the New York City Health Department and other preventive services, as well as the disappearance of needed treatment services in both the public and private sectors. But most of you have heard more than you ever wanted to know about the problems of the Bronx and, besides, the home of the Yankees may be poorly received in the home of the Red Sox.

I could, perhaps, concentrate on China; present data on the remarkable changes in infant mortality and life expectancy over the past thirty years; and discuss the lessons I believe other countries—both developing and developed—can learn from the Chinese health care system. But most of you have heard more than you ever wanted to know about medicine in China and, besides, paeans to the barefoot doctor,

**"Aesculapius," as the ancient god of medicine is more commonly known at Harvard, is drawn from the Latin spelling of the name of the Roman god. "Asklepios" is a closer transliteration of the Greek spelling of the name of the Greek god.*

to acupuncture and herb medicine may be somewhat jarring in this home of highly specialized clinical and basic science.

It seems better, for this occasion, to concentrate on a metaphor. The obvious subject for this metaphor would be Hippocrates and his disciples, who are closely linked with our memories of this quadrangle. But I prefer to go beyond history and even pre-history, and to use legend and belief as my source. And so I call to join us at these rites a trinity of Greek gods: father, son, and grandson—Zeus, Apollo, and Asklepios.

Zeus, as you know, was the chief deity of the Greek pantheon, the ruler and protector of the other gods and also of humans. Known to the Romans as Jupiter, Zeus was an absolute monarch and, as might be expected, had his share of macho. He was known for his sexual escapades, a source of continuing discord with his wife, Hera. Among his many offspring were Hermes, the god of commerce (known to the Romans as Mercury) and Ares, the god of war (known to the Romans as Mars). Zeus, in the ultimate act of male chauvinism, produced Athena full grown from his own head. Indeed, all the children of Zeus are worth talking about, but the offspring that we are mainly concerned with is Apollo.

Apollo was the most widely revered of the Greek gods. Zeus was feared,

but Apollo was loved. He was the god of light, truth, and prophecy. He was also the god of crops and herds, the averter of evil whom the shepherds and farmers worshipped. He brought order and harmony, stood for moderation and sobriety; on his temple was graven, "Nothing in excess." Apollo was the artist-god, the musician and poet. If Zeus was power, Apollo was reason, enlightenment, trust, and joy.

As you might expect, Apollo also had many love affairs, but his were far less successful than those of Zeus. You will recall, for example, that Cassandra, the daughter of King Priam of Troy, rejected Apollo's advances and was punished in a strange way—by being doomed to always utter true prophecies, but to have no one believe them until it was too late.

Another of Apollo's liaisons was with the nymph Coronis. While she was pregnant Apollo sent his sister Artemis (known to the Romans as Diana, the huntress) to kill her. She died before the child was born, and it was brought into the world through what we now call Caesarian delivery. The child was named Asklepios.

Like all physicians that followed him, Asklepios required preceptors in the art of healing. Asklepios' instructor was Chiron the centaur, half-horse and half-man, a heroic figure to the Greeks, the personification of the combination of power and rationality. Chiron's name is derived from the Greek word for hand, the root of the words "chirurgy" (now surgery) and "chiropractor." (You may also recall that Chiron was accidentally pierced by a poison arrow shot by Hercules; he renounced his immortality in favor of Prometheus, the creator of mankind, and was placed among the stars as the constellation Sagittarius, the archer. If, in the middle of the night, you want to thank or blame our still-remembered teachers, you can look into the sky, see their progenitor, and visualize them—lovingly or otherwise—as half-person, half-horse.)

To return to our main theme, Asklepios had two daughters: Hygieia, who believed that medicine's prime function is to discover and teach the natural laws that enable people to stay healthy, and Panakeia, who used medicine derived from plants to heal the sick. Asklepios' fame as a healer became so great that temples were built in his name. Sick people came to the temples to sleep overnight in the hope of being cured or of having their

remedies revealed to them in dreams. That overnight stay is, of course, reminiscent of a more modern institution.

Asklepios' symbol, incidentally, was a simple staff with a single serpent coiled about it. The caduceus that is often used as the symbol of medicine—a winged staff with *two* intertwined serpents—is the magic wand of Hermes, the god of commerce.

If you are charitable, you are probably saying by now, "All this is interesting, possibly even entertaining, but what has it to do with a medical school reunion?" Ah, we're coming to that.

Asklepios, you see, died a political death. One of the legends is that Zeus' brother Hades, god of the underworld (known to the Romans as Pluto), noted that Asklepios' healing prolonged life on earth—he could even restore the dead to life—which diminished the population of Hades' nether realm. When Hades complained to his brother, Zeus promptly ended his grandson's work by killing him with a thunderbolt.

The point, of course, is that the light, truth, and joy of Apollo are not enough; that the natural laws of Hygeia and the medicines of Panakeia are not enough; that the technical lessons of Chiron are not enough. One of the most important determinants of the success or failure of medicine is power—specifically the power of a society and its leaders to preserve health and battle disease. Society and government can give life to medicine, can imbue it with the structure and function that permit it to work, or society and government can destroy medicine's ability to be of service to people and to patients.

The metaphor I've chosen applies to a number of present-day issues. One has to do with the current Zeus in Washington withdrawing enormous resources from the efforts of Asklepios in order to give them to Ares, the god of war—to turn them from healing to killing. The largest peacetime budgetary increases for the military in U.S. history are planned: a seven percent annual increase in real terms beyond inflation, for a total of 1.6 trillion dollars over the next five years.

This fundamental shift in federal spending priorities will destroy by means of the economic distortions it causes and the services it eliminates, as well as by the arms it produces. Those arms, of course, contain thunderbolts

Physicians will be more and more caught in the middle, between their patients and what has been defined as the "new medical-industrial complex."



that Zeus might envy—among all the world's nuclear powers the equivalent of 20 billion tons of TNT, four tons for every human being—thunderbolts that can give Hades all the population he ever desired and possibly turn the entire planet into a nether world.

The metaphor also refers to the issue of health promotion and disease prevention, in which we see a growing tendency to blame the victim. Smokers are blamed for their lung cancers; drivers who don't wear seat belts for their injuries; workers for their work-related accidents or even work-related diseases. The cause, dear Brutus and dear classmates, lies neither in our stars nor in ourselves. It lies with a government that subsidizes the tobacco industry, that refuses to require passive restraints in automobiles, and that per-

mits industry to avoid instituting the engineering controls that would prevent much occupational illness and injury.

The metaphor refers also to the very structure of medicine in the United States, which—as the public sector is systematically and purposely decimated—increasingly owes more to Hermes, the god of commerce, than to Asklepios. Again the issue is power, but here it is the power of the corporations that are increasingly taking over medicine. As you may know, multi-hospital, profit-making corporations now control 31 percent of the community hospital beds in the United States; and it is predicted that they will eventually control 85 percent of these hospital beds.

Their for-profit structure drives

these corporations to skim the cream off what they call the "medical care business." Orthopedic care for young people with sports injuries, for example, is generally profitable; repair of fractured hips in older people with other medical and social problems is generally unprofitable. The first group of patients is solicited by the private sector; the latter group is often left to the public sector. Physicians will be more and more caught in the middle, between their patients—particularly their poor or minority patients and their chronically ill and disabled patients—and what the editor of the *New England Journal of Medicine* has defined as the "new medical-industrial complex." Physicians will have to decide which side they are on.

I do not often put my faith in physicians as protectors of the poor and helpless. However, in the increasing struggle to define medicine as either corporate business or as public service, I think many doctors will find themselves on the side of their neediest patients, in part because that position may increasingly coincide with the physician's wish to maintain some measure of control over his or her own practice.

What can physicians do about these issues? They can be leaders in the fight for their patients and their communities. If they were to do so, some of the turn-around in services, entitlements, and regulations could even come during this Administration. It is already backing away from some of its earlier positions in health, apparently in response to pressure from concerned people.

The Department of Health and Human Services, for example, had released plans to relax federal regulations dealing with nursing home residents' rights and with the standards of care. Following strong protests by physicians and others, it was forced to maintain the regulations. In similar fashion the Administration can be forced to return resources to health and human services, turning the current disaster into a transient rather than a long-term one. Beyond that, many physicians are already working hard, through Physicians for Social Responsibility and other groups, to prevent the possibly irreversible catastrophe that nuclear war would represent.

Physicians, I believe, have a special responsibility to fight back against the actions of this particular Zeus for

several reasons. They have special knowledge of what cuts in health and human services will mean and special knowledge of the medical consequences of a nuclear war. They have a special responsibility because it is part of their duty to defend their patients and communities against disease and untimely death. They also have a special responsibility because of their status in the community. I do not defend physician elitism, nor do I defend physicians' using their status to act as deities. I am rather suggesting that their status gives them a responsibility to teach and to motivate others.

The point I want to leave you with is this: It is not sufficient—if we would be healers—to rely only on our medical knowledge and skills, so painfully gained; it is not sufficient to rely only on our compassion and empathy, so painfully preserved; it is not sufficient to work conscientiously and selflessly, in the midst of an often uncaring and self-seeking society. The other necessary element, if we would be healers, is advocacy—the use of our power on behalf of, and the transfer of power whenever possible to, those in greatest need.

The image I want to leave you with is not of Greek deities or even of Hippocrates. I want to leave you with an image of a pathologist, Rudolph Virchow. Virchow worked in Berlin, in what was then Prussia, in the middle of the last century. He was a pioneer in using cell theory to explain the effects of disease in organs and tissues. He coined the words "thrombus" and "embolus" as well as many other currently-used terms and concepts, and is remembered throughout the world for his brilliant contributions to the science of pathologic anatomy.

But Virchow is also remembered for other contributions. In 1847, at the request of the Prussian government, he traveled extensively in rural areas to investigate a severe typhus epidemic. He recognized that the real causes of the spread of typhus were poverty, malnutrition, and their accompaniments. Based on his findings, he recommended a series of economic, political, and social changes that included full employment, higher wages, local autonomy in government, agricultural cooperatives, and a more progressive tax structure. Illness, he argued, has its origins in social problems; and medicine, to be successful, must be mainly a social science.

Virchow also combined his medi-

cal work with direct political action. In 1848 he joined the first major workers' revolution in Berlin. He was later elected to the Berlin City Council and to the Prussian Diet, where he was a founder of the Progressive Party and an outspoken opponent of Otto von Bismarck. Virchow fought for a bill to regulate the processing of pork products to prevent trichinosis. Bismarck challenged Virchow to a duel. As the challengee, Virchow had the choice of weapons and proposed that two sausages be prepared, one full of trichinae ova, with Bismarck to have the first choice of sausage to eat. Bismarck withdrew, and the bill passed. Virchow's advocacy was consistently on behalf of the poor and powerless. The physician, Virchow argued, is the "natural advocate for the poor."

On this occasion that reminds us of our friendship and our accomplishments, let me emphasize that by suggesting broader, and indeed different, responsibilities for physicians, I do not mean to imply that the responsibilities you have so successfully undertaken have not been difficult ones. But I firmly believe we must use our ability, our training, and our commitment to make ours a profession that fights for the services that our patients and our communities need, and that fights against the destructive diversion of our national wealth.

We must use our ability, our training, and our commitment to make ours a profession in which sharing of knowledge and power, and advocacy for those in need, are seen as part of our work. We must use our ability, our training, and our commitment to make ours a profession in which we need not be deities in order to help others—a profession that strives to make a world in which all can survive and can truly be human. We will achieve better, more accessible, more equitable health care, and indeed a safer and more just world, because we must. May we never lose our passion for the things that really matter. May we carry with us—and use for good—the power of Zeus, the light, truth and joy of Apollo, and the healing of Asklepios. □

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In Philadelphia They Ask — Who Were His Parents?

by John L. Lewis

The invitation to take part in this Alumni Day program gave me pleasure when I received Perry Culver's letter back in February. The opportunity to return to Boston to visit classmates, friends from other classes and faculty sounded wonderful. It was only when I reread the letter that I realized how Harvard-like the requirements were: The talk was to be "personal, interesting, humorous, have a catchy title, describe accomplishments, and last anywhere from fifteen to seventeen minutes." Obviously I was taking yet another exam in the quadrangle.

Since my academic field is obstetrics and gynecology, one might guess from my title that my talk will deal with genetics or high-risk obstetrics. Or perhaps I might recount some experience related to Philadelphia. Or, as George Bray suggested last night: I have moved to Philadelphia and they want to know if my father was a coal miner. Actually it's not related to any of these possibilities. As a matter of fact, I chose it because of the two lines which follow in the full quotation. It was Mark Twain who said, "In Philadelphia they ask, 'Who were his parents?'; In New York, 'How much is he worth?'; In Boston, 'How much does he know?'"

There was an obvious implication: New York was a financial center, but not in the mainstream of academic and intellectual pursuits that flowed so

freely through Boston. Having trained in Boston for eight years after medical school, I am aware of the local feeling that almost everything implied in Mark Twain's observation is still valid today. However, having also had the opportunity of working at three academic institutions in New York over the last fifteen years, I would dare to suggest—however heretical it may seem at this meeting—that academic medicine is alive and well outside of Boston, even in New York City.

Having said that, I must admit that there remains even today some truth in Twain's observations about the importance of money in New York. In early 1977 my class at Harvard College was getting ready for its twenty-fifth reunion. There were several dinners at the Harvard Club of New York City to develop interest in having everyone return for the reunion. At one of these I ran into a classmate whom I had known primarily as a hockey player. He said, "Red, in college I remember you were a premed. Did you ever go to medical school?"

I said, "Yes," and he asked me what I was doing now. After I described my position at the Memorial Sloan-Kettering Cancer Center he said, "That's interesting; you know I'm on the Board of Managers there. Actually, I'm on the Finance Committee."

I remarked that both of us having been there so long without the other's

knowledge said something about the institution. And that ended the conversation.

Then during the reunion week, as one of the formal speakers, I gave a view of the current status of cancer care and research. The next day the same person came up and said, "Red, I heard your talk and I've been listening to some of the other doctors in our class. You seem to have a strong reputation in your field." I thanked him. Then he said, "But if you're that good, why do you work for the salary we pay you?" I wouldn't expect to hear *that* from a board member in Boston.

Although it would be fun to try to further develop the theme of medicine flourishing outside Boston's academic mainstream, I would like to turn back to the request in Perry Culver's letter that "Hopefully, you will talk about some of your interesting experiences." To do that, I would like to talk about the development of the subspecialization of gynecologic oncology.

Because I served as chairman of a committee that studied this area, and then as first Director of the Division of Gynecologic Oncology of the American Board of Obstetrics and Gynecology, my memories of this development remain strong, personal and often traumatic. It was a journey into the middle of a medical "establishment," an area where I was not very comfortable. My remarks will obviously be based on personal observations and are therefore subject to all of the biases which come from that approach.

In 1970 the American Board of Obstetrics and Gynecology acted upon the growing realization that there were at least three areas of expertise too specialized to be adequately transmitted to all core residents in OB-GYN. These subspecialties were gynecologic oncology, maternal-fetal medicine and reproductive endocrinology. Three subsidiary divisions of the board were appointed to make recommendations and implement programs for the training, examination and certification of individuals wishing to become specialists in these areas.

Because significant changes in OB-GYN have taken place as a result of this recognition and formalization of advanced certification, I will try to point out some of the key decisions made, describe the process, and give my opinion of the results—limiting my discussion to gynecologic oncology. It is important to acknowledge that this kind of work had been going on for

Having had the opportunity of working at three academic institutions in New York over the last fifteen years, I would dare to suggest – however heretical it may seem – that academic medicine is alive and well outside of Boston.



years. It was the formalization of training and establishment of standards of evaluation which were new.

To assure that there would be no so-called subspecialists who were not qualified first as OB-GYN specialists, our first decision was that subspecialty training could begin only after completion of the full residency training. In addition to lessening the divisive effect on the specialty, this requirement made certain that the oncologists would have the knowledge of physiology, function and benign pathology taught in a standard OB-GYN residency. Our original recommendation was that training last at least three years, but the parent board subsequently pared it down to

two years.

The second decision was that this new type of specialist should have training and experience in all effective forms of therapy for gynecologic malignancies: radical surgery, radiation therapy and chemotherapy. This was a critical decision, for although there were many who thought that the extra work should be limited to increased surgical training, the requirement has enabled subspecialists to function particularly well in multimodality collaborative trials.

Finally, one of the most controversial decisions was to require even so-called “grandfathers” to go through the same evaluation process as trainees in

order to be certified. Gynecologic cancer fellowship programs had existed in many institutions long before 1970, and some of the graduates of these programs had training essentially equivalent to that of current residents. Others had become experts through experience and practice. However, in order to protect the significance of the certificate of special competence, all individuals were evaluated by the same examination process.

I'll briefly list the skills and knowledge to be attained in a two-year training program, the requirements to be met, and the certification process. Although this may sound tedious, it is important to know some of the details in order to know what these people can do – and also to know why this development has had effects on other medical specialties.

The following skills and knowledge are to be attained:

Surgery: Ability to perform independently all of the standard radical gynecologic operations and also those procedures needed to manage intestinal and urologic problems due to the growth of gynecologic malignancies or their treatment (This phrase was approved by the American Board of Medical Specialists in 1972, thus precluding some of the potential jurisdictional disputes with general surgery and urology).

Radiation Therapy: Knowledge of principles of radiobiology and experience in brachy therapy and treatment of complications.

Chemotherapy: Basic knowledge of clinical pharmacology of chemotherapeutic agents and capability in their use.

Pathology: Knowledge of appropriate gross and microscopic pathology.

Clinical Research: Understanding of investigative concepts and techniques.

In order to be approved, a training program needs:

- 1) Adequate patient population made available for trainees' education and experience
- 2) Facilities for comprehensive cancer care: surgery, radiation therapy, and chemotherapy

- 3) Sufficient personnel in each of these areas for the additional obligations of teaching and clinical supervision, and clinical care

During training each fellow must record and submit for review a training program log which lists not only his rotations but details of all of his clinical experience. For example, after a surgical procedure he would list the procedure, pathology, and his role as surgeon, co-surgeon or assistant. Such records have been very useful in evaluating the actual training which programs make available to trainees.

The requirements of the certification process can be briefly summarized:

- 1) Two years of practice experience as a gynecologic oncologist in a center providing adequate facilities for comprehensive cancer care
- 2) Individual case list describing that clinical experience
- 3) Submission of a thesis based on clinical or laboratory research
- 4) Passing a written examination after training and an oral examination after the two years of practice

The program is arduous and, as one would expect, the number of trainees is not large. At the end of 1981 there were 202 individuals who had been certified for special competence in gynecologic oncology. There were 35 approved training programs in the United States. During the preceding five years, 25-29 fellows completed their second year of training.

What have been the results? Obviously this is the area of greatest potential for bias in interpretation, but it is my opinion that the overall results have justified the effort. Evaluation can be made on the basis of the goals listed originally by the Division of Gynecologic Oncology:

- A) **Elevating standards of education and training relating to gynecologic oncology.** This has occurred not only in the fellowship programs but also in core residencies. The inclusion of a trained gynecologic oncologist in the faculty of core residency programs has upgraded not only cancer education and care,

but also the level of surgical competence.

- B) **Enhancing recruitment of qualified physicians to the field.** My personal bias is that they get better each year.
- C) **Improving the organization and distribution of patient care.** The organization of institution-based services which offer all effective forms of treatment and programs of multi-modality care has made possible the selection of the most appropriate care for each patient.
- D) **Increasing knowledge in the field.** Evidence of this growth comes from various sources, including scientific articles, specialty journals and scientific meetings related to the field.

Clearly, in the long run, the value of this effort will be determined by whether women with gynecologic cancers get better care. That, and that alone, will be the measure of success.

I'd like to thank the Reunion Committee for this invitation. It is good to be back in a city which still places primary value on "what one knows." I am proud that in the medical community Harvard Medical School is the focus of that value system. And I, like many of you, feel that this school has been of primary importance in exposing me to the information, values, and people that make me grateful to have been here. □

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A Near Fatal Case of Potomac Fever

by George A. Bray, Jr.

Introduction: Potomac Fever is a well recognized entity occurring among people living in proximity to the Potomac River. Many individuals who venture into the Potomac Valley are afflicted with an illness which is often progressive and leads to a languishing inertia for the rest of their lives. By current estimates more than two million people have a terminal form of this disease. In this brief report, I shall

present a case of Potomac Fever which was not fatal and in which rehabilitation and cure have occurred.

Case Report: The patient was a 47-year-old Caucasian male who presented with a chief complaint of delusions of omnipotence and the belief that by working for the United States Government he could improve the lot of mankind. The present illness began

in the spring of 1978, and the entire illness lasted only eighteen months.

Present Illness: Prior to 1978 the patient had been residing outside the Potomac Valley in his usual state of good health. In the spring of 1978 he visited the Potomac Basin for one month, when he first breathed the infectious air of the region. During that brief time he worked for a Deputy Assistant Secretary of Health in the Department of Health, Education and Welfare. His job was to develop a proposal for a National Conference on Nutrition Education. This short sojourn was accompanied by his first delusions of omnipotence.

Upon leaving the Potomac Basin the patient returned to normal health, and the delusions disappeared. Approximately two months later, in July 1978, he received a feverish call from the Assistant Secretary of Health asking him to come back. The patient reported an irresistible urge to return to the steamy and heady vapors of the Potomac Basin. Following interviews with the Assistant Secretary of Health and with Secretary Califano, the symptoms worsened.

In the Fall of 1978, the patient returned full-time to the Potomac Basin to serve as the first Nutrition Coordinator for HEW. The delusions of omnipotence, which had subsided after his departure from the Potomac Basin, returned; and for the next nine months the patient found himself almost continuously agitated. The effluvia of the environment afflicted him again. During the nine months in this infectious environment he became almost hypomaniac.

He was intense but agitated when he talked about the National Nutrition Education Conference which was held in the fall of 1979. His eyes seemed fixed and staring, and perspiration beaded on his forehead as he described the development of a set of Dietary Guidelines. After the groundwork for these Guidelines had been laid, the final document was completed in the fall of 1979 and promulgated in a joint action by the Department of Health, Education and Welfare and the Department of Agriculture.

The patient vividly recounted working on the implementation of a Congressional request for monitoring the nutritional health of the American people. He revealed a neurotic preoccupation in an emotional outburst about the poor financial basis of sup-

A prominent feature associated with many cases of Potomac fever is the delusion that all good flows from the Potomac basin.



port for nutrition research. His fevers became worse during times of consultation at the White House and at the Capitol. The possibility of succumbing to Potomac Fever was now obvious. His delirium began to concern his loved ones, friends and acquaintances. After months of delusion and fever, there was a crisis in the summer of 1979. The fever suddenly lysed when the patient was evacuated from the Potomac Basin to recuperate in the smog of Los Angeles.

Review of Systems: The review of systems was within normal limits except for the altered mental status noted above.

Family History: There was no prior family history of exposure to Potomac Fever and no known history of men-

tal or metabolic diseases.

Social History: The patient had been employed as a professor at UCLA, with no history of drug, alcohol or tobacco abuse.

Past Medical History: Was entirely within normal limits.

Physical Examination: Physical examination revealed a well developed, apparently healthy male with obvious agitation and flushing. Blood pressure was normal, but there was a low-grade fever of 99°. Examination of the skin revealed warmth but no discreet lesions. The conjunctiva were slightly injected, and the eyes blinked infrequently and often stared into the distance.

The ENT exam was unremarkable. The cardiac exam revealed a slight tachycardia (Rate=96), but there were no murmurs. The lungs were clear to percussion and auscultation, but there were occasional sighing respirations. Abdominal exam was within normal limits except for his flushing. The patient was oriented to time, place and person but he continued to tell about his desire to help solve the nutritional woes of Americans by working in the Potomac Basin.

Laboratory Data: A complete blood count and urinalysis and a multi-channel analyzer for blood chemistry were within normal limits. Chest X-ray and electrocardiogram were likewise within normal limits except for the tachycardia.

Commentary: In reviewing this case and other cases of Potomac Fever in the literature there are several clinical lessons. First, the prevalence of Potomac Fever among individuals who languish for too long along the Potomac River approaches 100%. The two principal factors associated with the risk of developing Potomac Fever are the duration and intensity of exposure to the infectious environment. The longer the duration of exposure, the more difficult it is to escape the environment which produces the fever.

For an individual at risk, it is important to keep the period of exposure as short as possible. Indeed, it would even be beneficial if there were no permanent residents of the Potomac region. From the vantage point achieved by review of this case and other cases of this disease, I would *strongly* recommend that anyone residing in the Potomac Basin and working for the Federal Government be rotated out of that environment to a more salubrious climate at least every two to three years.

A second prominent feature associated with this and many other cases of Potomac Fever is the delusion that all good flows from the Potomac Basin. For those who become imbued with the regulatory fever of this region, the concept of individuality becomes blurred and may disappear. Regional and cultural differences fade. The concept of uniformity and the desire to reduce individual excellence to mediocrity arise from the feverish bureaucratic mind.

A third feature which emerges

from a review of the literature is the similarity between most of those afflicted with Potomac Fever. In general, they belong to a group that might be described as the "Chablis and Brie" set: that is, they are liberals (often with an Ivy League education) who are dedicated to the proposition, right or wrong, that the wellsprings of "good" originate along the Potomac River.

My final comment deals with the clinical course of the "fatal" cases of Potomac Fever. In most instances the early excitement and exhilaration associated with the beginning of the fever fade as the regimentation of the bureaucracy becomes a fact of life. To escape this fate requires special care. In the present case, the ties to the Potomac Basin were not economic; that is, the patient did not receive all of his financial support from the Federal Government. In this position he was able to accomplish most of the things he set out to accomplish: He was able to develop and implement a Nutrition Education Conference which set goals for the 1980's. He was able to lay the groundwork for the Dietary Guidelines which were published in 1980. He was also able to work towards organization and coordination of nutritional activities within the Department of

Health and Human Services.

It is clear then, that the Potomac Basin—for all of its homogeneity and risk of Potomac Fever—nonetheless offers significant opportunities for solving problems. Had the duration of exposure continued beyond one year, however, the likelihood of further accomplishments would probably have decreased, as the inertia and lethargy of this febrile disease weakened the will to do battle with the "system."

In closing, it is important to remember that Potomac Fever need not be fatal. To avoid this languishing death, limits must be set on the duration of exposure and efforts must be made to minimize the intensity of this exposure. In the two years since the patient left the Potomac Basin, the symptoms of the disease have disappeared. The patient has made a complete recovery to his usual state of good health, and there has been no residual evidence of his bout with Potomac Fever.

Thus, even the smog of Los Angeles is not as virulent as the vapors of the Potomac Basin. □

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Life Among The Giants

by John P. Merrill

When I was asked to talk on Alumni Day I was given a set of definite instructions. They were: 1) to have a message, 2) to provide humor, and

3) to be brief.

I hope that I will be able to follow all of these directions. First, the message: I have learned from more

than thirty years of teaching medical students, house officers, and post-graduate fellows that they are sadly lacking in knowledge of the great past of Harvard Medical School and the medical giants who have made it great. This fact is accentuated by the celebration of our Bicentennial. For example, not one student in the past thirty years has known of Austin Flint, an HMS graduate who was in the mid-nineteenth century what William Osler was to Hopkins, McGill, and Oxford somewhat later.

Less than half the students I have talked with in the past two years (can you believe this?) have known who George Thorn is. In the sixties, to be sure, it was thought *déclassé* to have or even to want to have this kind of information. As I remember, in the sixties a professor was literally afraid to walk into a classroom for fear of being hissed. Those students who weren't asleep were reading *The Village Voice*, or scratching themselves, or combing their beards.

Fortunately, all of that has now passed; and when I talk now to the students about great men, these giants, their little eyes open wide and their breath comes faster. They also listen attentively when I discuss the difference between types 1, 2, and 3 renal tubular acidosis (a nephrologist may see three such cases in a lifetime). But what really grabs them is when I discuss the giants of medicine. I realized with a start when I was putting this essay together that I, and many of you, actually lived and grew up professionally in a world populated by some of these giants. Since most of my time as a clinical clerk and house officer was spent at the Brigham, I have limited my discussion to the people I knew there, and unfortunately could not include other giants of those times—of whom there are a good many, including Bill Castle and Max Finland.

Most of us from the class of 1942 remember our first encounter with anatomy. The professor was Robert *Montraville* Green, who sported a bushy head of reddish blond hair, and a mustache of the same material, but waxed and turned up at the ends. He was, mind you, not only Professor of Anatomy at Harvard, but also Professor of Greek at Radcliffe, and was further distinguished by the fact that his father was immortalized in Fritz Irving's poem "The Ballad of Chamber Street." His father was Charles *Montraville* Green, to whom Irving

referred as "Charlie Green with his little round hat, his walking stick and his beard of pubic hair." (As an aside let me mention that I knew Joseph Pratt, whose son married a cousin of mine. Joseph Pratt founded the Pratt Diagnostic Clinic, which is now the Tufts-New England Medical Center, and, again in Irving's epic, he was the constant companion of Charlie Green and known as "Joe-Joe" Pratt.)

In any case, Bobby Green walked into the amphitheater where we first-year medical students had been assembled and were watching with mixed anticipation and horror an obviously human form covered by a sheet on a litter beside the lecturer's desk. Bobby Green proceeded to give us a few eloquent sentences on the dignity of the human body and then whipped the sheet aside and *there* was a *naked* corpse. To most of us it was our blast-off into the orbit of medical school.

The next giant we encountered was Elliot Carr Cutler, the Moseley Professor of Surgery at HMS who succeeded Harvey Cushing at the Peter Bent Brigham Hospital. There was a tremendous dynamo, a fantastic teacher and an inspiration to the students and house officers. He must have been the greatest extrovert—without being offensive—that I have ever known. He talked to our class on the second day about "Becoming a Doctor," and his concluding words were: "All of you are here because you have been selected as outstanding scholars and men. You must never forget that if you work hard enough, with all of these attributes, there is plenty of room *up here at the top*."

Well, we chuckled about this for two years. In our third year we attended a lecture at Children's Hospital. Most of you know the amphitheater at Children's, which goes up at a slope of about sixty degrees. In the front row were seated the full professors, behind them the associate professors, then the assistant professors, and so on, until way up in "peanut heaven," in the very last row, were the third-year medical students. Elliot Cutler arrived a few minutes late for the lecture and found that the front-row seats were all occupied. As he looked around for a place to sit, a voice from the third-year student row (I believe it was that of Ned Kelly) said, "There's plenty of room *up here at the top*, Dr. Cutler." Well it took a few minutes before the crowd had quieted down and the lecture could begin.

Elliot Cutler, by the way, published in 1924 with Sam Levine an article in *The Archives of Surgery* entitled, "The Surgical Treatment of Heart Disease," in which he discussed his attempts to alleviate mitral stenosis. In 1924 he lacked the anesthesia support and the technique to perfect this procedure, but it was obviously a first that should be recognized.

Then there was Frederick C. (Fritz) Irving, the William Lambert Richardson Professor of Obstetrics at Harvard, and Chief at the Boston Lying-In Hospital. His book was our standard text for obstetrics. Although Irving always denied it, he *was* the author of the fabulous "Ballad of Chamber Street." I have seen the original manuscript in his own hand. He ruled the obstetrical domain in the manner of the Viennese professors, and there is no better illustration of this than the following anecdote.

A very pregnant young woman was rushed to the Boston Lying-In in a screaming taxicab. As many of you will remember, there was a circular driveway in front of the hospital which surrounded a plot of grass. She tumbled out of the door, unable to get into the hospital, and a clever young obstetrical resident ran out and delivered the baby safely and happily on the well manicured lawn.

Her course in the hospital was uneventful, and when she came to leave she received the usual bill: \$75 for postnatal care, and a \$50 delivery fee. She objected vigorously to the delivery bill. The house staff were unable to cope with this problem so they handed it to the visit, an assistant professor. He wasn't quite sure what to do, so he bucked it up to the associate professor, who took it to the chief, Dr. Irving. Irving looked at it for a moment over his half glasses, scribbled a little notation on it, and it went back through the channels to the patient. It now read: "\$75, postnatal care; \$50, greens fee."

Then there was John Homans, Professor of Surgery and the author of the textbook which all of us in medical school used as a standard. John Homans, when I knew him, was slightly balding and a little stooped and had a wonderful lisp which made him an easy mark for the satirists of the Aesculapian Show. Of the many legends about Homans, one which I like is the story of the day when, after finishing his surgery and in a hurry to see his first patient in the afternoon,

he dressed in haste and walked out of the dressing room in his street clothes having forgotten to button his fly.

He began to button it while proceeding apace, and a student nurse—seeing the great man in this act—blushed beet red, turned around and fled. Homans shouted after her, “Nurth, come back here.” The girl stood frozen in her tracks, then turned around, and Homans said, “Nurth, when you see John Homans buttoning his fly, you don’t have to run. The time to run is when you see him unbuttoning it.”

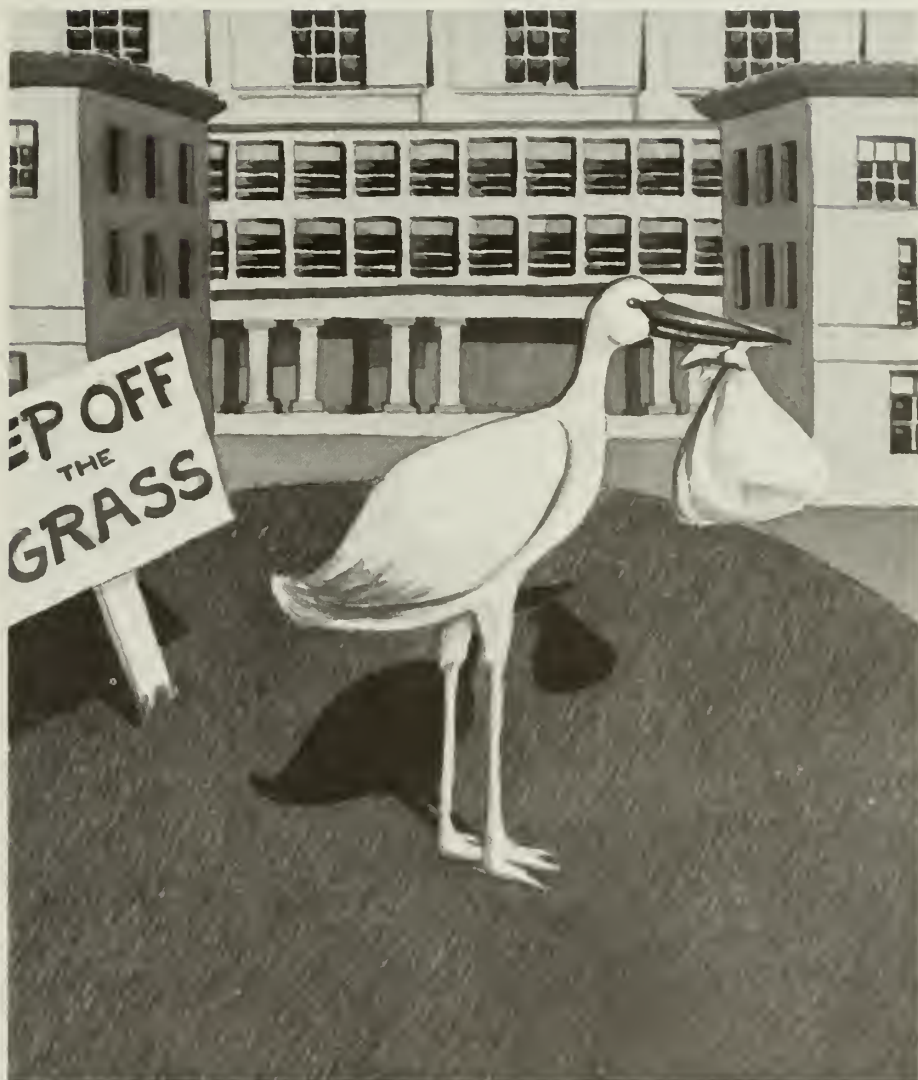
Soma Weiss, whom I knew when I was a medical student, entertained us at his home one day. It was a warm day, he had a keg of cold beer, and I offered to open it for him. In the process I established a leak in the bung and wetted down the Hersey Professor of Theory and Practice of Physic with about a quart of lager beer. I remember thinking, as I watched him drip, “Oh well, there must be other internships than at the Brigham.”

Of more recent vintage there have been J. Englebert Dunphy, or Bert Dunphy, who became Chairman of the Department of Surgery at the University of California at San Francisco, and was President of the American College of Surgeons; Bob Zollinger, Chairman of the Department of Surgery at Ohio State and also President of the American College of Surgeons; and J. Hartwell Harrison, the Elliot Carr Cutler Professor of Urologic Surgery at Harvard, and President of the American Association of Genitourinary Surgeons.

Bert Dunphy was largely responsible for my decision to enter internal medicine. When I was a third-year student in Dunphy’s surgical section, a patient entered with abdominal pain—in retrospect, an obvious appendicitis. In my differential diagnosis I discussed lupus erythematosus, tuberculous peritonitis and intestinal angina. When I finished what I thought was a rather learned discussion I asked, “What do you think, Dr. Dunphy?” Dunphy cocked his head, gave me a quizzical look—a habit of his when he thought his informant was way off base—and then said, “Young man, what I think is that if you go into surgery it will be a catastrophe for the profession.” That’s why I am an internist.

Perhaps one of my most personal recollections of the latter-day giants was my encounter with Robert Zollinger and J. Hartwell Harrison. Zollinger at

*After Irving was through with the disputed bill, it read:
“\$75, postnatal care; \$50, greens fee.”*



that time was surgeon to the medical students, and Hartwell the urologist. I had a wart on my finger which Zollinger had agreed to fulgurate. Unfortunately, I had never met either of these two giants and I made the wrong turn, ending up in the Urology Department, where Harrison greeted me with a large smile. At the time he was expecting a student with hematuria whom he was planning to cystoscope. Of course, I thought that he was Zollinger who was going to take my wart off. He gave me a big broad grin and said, “This won’t take more than a minute, son; just take off your pants”—at which I fled as rapidly as

the student nurse before John Homans.

Then there were Eugene Eppinger, Sam Levine, Dorothy Murphy, Carl Walter and, of course, Franny Moore—the only man who could have taken Elliot Cutler’s place. Franny introduced the isotope dilution measurement of body fluids, a giant step forward by a surgeon in a terrain until then dominated by pediatricians and internists.

Then, of course, there is George Thorn, my friend and mentor, from whom I not only learned a great deal of medicine but with whom I also played in a Dixieland jazz band. He was on the banjo and I on the clarinet.

(Can you imagine one of the world's great endocrinologists and The Hersey Professor of Physic at Harvard playing, "I Wish I Could Shimmy Like my Sister Kate" on the banjo?)

Certainly the very prototype of the giant who is the subject of my essay was Merrill Clary Sosman, one of the best clinical radiologists of his era or any other, and when I say clinical I mean this: Merrill Sosman was the only radiologist ever to have been appointed Visiting Physician-in-Chief Pro Tem at the Peter Bent Brigham Hospital, and I can attest to the fact that he did a masterful job during his week of tenure. His X-ray conferences on Tuesdays were masterpieces. Once a year he would devote one of those conferences to the radiology of animals, calling upon talent from nearby Angell Memorial Hospital. It was there that I learned for the first time that one of the major problems in elderly male dogs, as in humans, is prostatism. We were shown several films of large over-extended dog bladders with bulging hypertrophied prostates.

Sosman's greatest feat, however, occurred at one of his usual Tuesday X-ray conferences. In those conferences the other giants were always seated in the front row and Sosman continually badgered them with questions about what the shadow-graph showed. One day, showing a picture of an obviously distorted foot, Sosman asked first Bert Wolbach and then Sam Levine to examine the film, and when neither one of them knew the answer he queried first the second and then the third row, and when no response was forthcoming he asked, "Does anyone in the audience know what this X-ray shows?"

A young man in a white coat answered from the very top of the amphitheater. Sosman called him down. The young man looked at the film, then took off his glasses, polished them, and looked at it again and said, "Yes, Dr. Sosman, that is Ainhum, a syndrome first described by von Klock in 1892. I believe he published it in the *Allgemeine Zeitschrift von Krankenhäusern*. As memory serves, it was volume 14, page 223." The audience, which had by now recognized the distinguished scholar, broke into a roar of laughter. The young man, well rehearsed in his role by Sosman, was perfectly entitled to wear a white coat. He was Gabriel Spanley, the hospital barber.

In our own class, too, there are many giants—I am sure *real* giants to the students of today. There was Doug Farmer, the blocking back who made Tom Harmon famous and the clinical surgeon who held that department at Boston University together for many years before going to Yale. There is John Kirklin, who is widely known as the heart surgeon's heart surgeon. Not all of our giants were in academia. There was Charles Hutter, captain of the Harvard College swimming team, who almost singlehandedly beat Yale for the first time in eighteen years. His feats with the low-altitude parachute and the loppa-loppa fish added cubits to his stature.

Where are they now? As I get older and tend to live in the past perhaps I don't see them, and that may well be

the veil that age casts upon the failing eye. However, I wonder if the ones that are here now may well be giant achievers, but perhaps not giant people. I posed this question to my advisor in medical history, Mark Altschule, co-author of *Medicine at Harvard: The First 300 Years*, and he agrees with me that the flesh-and-blood giants are dead. The reigning philosophy is well expressed by the concluding lines of Irving's "Ballad of Chamber Street": "and Charlie Green has not been seen/and as for Joe-Joe Pratt/I do not know nor give a damn/where now he hangs his hat." □

John P. Merrill '42 is Professor of Medicine at the Brigham and Women's Hospital and a past editor of the Alumni Bulletin.



The Letter That Saved My Life

by Walter Pick

This autobiographical account was written many years ago and stored among my private papers, unpublished and unshared. Now, after 35 years of rewarding pediatric practice, I find the fortieth anniversary of my graduation provides the appropriate occasion to present it. I do so in deep appreciation for the privilege of having attended Harvard Medical School.

I dedicate these pages to Richard C. Webster '43A and Victor C. Vaughn

'43A, who accepted me as their roommate and made my transition to life in the States an unforgettable experience. I will always be grateful to them.

My whole being shook with the quiet but fierce excitement that can be caused only by the unexpected. At long last, the letter was in my possession.

Now, with the lapse of years, I reflect upon those times when life

literally hinged on a scrap of paper. . .

I had been born into a happy childhood and upbringing in the Sudetenland of Czechoslovakia. For 25 years my father had derived a modest living from a small retail business in men's clothing. Our family life had been simple and good. We had lived in close harmony with those who were dear and had enjoyed the comfort of familiar surroundings.

In the fall of 1938 I was about to start my third year as a medical student at the Charles University in Prague. During those weeks the air was charged with endless rumors of Hitler's intentions toward the Sudetenland.

One evening I was surprised by the arrival of a telegram from my father telling me that the occupation of the Sudetenland was imminent, and that my parents were leaving their home of many years to join me in Prague. As I held the telegram, a chill wave of fear and foreboding swept over me.

My parents arrived the very next day. When I saw my mother smiling with tears in her eyes, I was gripped with the terrible realization that we, like so many others, had become refugees. With their few suitcases of belongings, which now constituted all their worldly goods, my parents moved into a tiny, two-room apartment. It was to be our last family home in Czechoslovakia.

Life seemed to grind to a complete standstill for me when the Jewish students at the University were peremptorily informed that they would not be readmitted for the fall semester of 1938. At 21, a student without a school, I had been thrown into a dangerously suspended existence. My parents, having no likelihood of employment, were living on exceedingly meager savings. The occupation of the remaining part of Czechoslovakia was expected at any time.

In desperation, I applied to various medical schools overseas for scholarships. Exploring every possibility, I also wrote to a former high school English teacher, asking whether he could suggest some course of action. By return mail, I received a letter with the address of a teacher friend of his in New Zealand, and a promise that he would write a letter of introduction in my behalf.

About six weeks later the first response arrived. The stranger in New Zealand had been so touched by my situation that she was making every effort to adopt me. The arrangement

Life seemed to grind to a complete standstill for me when the Jewish students at the University were peremptorily informed that they would not be readmitted for the fall semester of 1938.



called for me to work for her parents on their farm. After resettling in New Zealand, I would decide for myself whether to continue my medical studies.

The plan sounded promising. My parents, too, were eager that I grasp this unusual opportunity. There ensued an exchange of many letters with the New Zealand government about the details of immigration. I began again to indulge the excitement of a glowing hope.

Then, suddenly, all my bright youthful dreams came crashing down once more. A final communication from New Zealand ("The government regrets to advise. . .") informed me that I was too old to be adopted and

that without money of my own in a New Zealand bank, the government considered me an impermissible risk.

The days that followed were suffused with a complete sense of helplessness and despair. I knew full well the fate that would befall me before much more time elapsed. The refugees from Austria and Germany were already suffering the infamies of the concentration camps. I tried to reconcile the attitude of the New Zealand government with the harsh realities that confronted me. It was an insurmountable task; my bitterness was profound.

In the meantime, in order to subsist I tutored students preparing for their examinations—the same exam-

inations which I was no longer permitted to take. The money I earned was spent largely in buying stamps for the many letters with which I continued to bombard universities all over the world. The mail deliveries became the ebb and flow of my existence, dealing a daily blow as the mailbox remained mute and unresponsive to my pleas.

At last the day came when I held in my hands the letter which at first I could only regard with incredulity. For weeks I had dreamt of receiving just such a letter. As I read and reread it, I knew that it offered my only chance to escape the mad world the Nazis were creating.

The letter stated that my application to Harvard Medical School had been approved. A scholarship of \$1000 covering my tuition and living expenses had been granted for one year. If my studies were satisfactory, the scholarship could be renewed each year. I was requested to report for the semester starting September 25, 1939. A simple letter, yet one that to me unambiguously spelled the difference between life and death.

Fired with new hope, I once again had all the needed drive and enthusiasm for the difficulties and uncertainties yet to be overcome. The distance between Czechoslovakia and the United States was still to be spanned.

All of Czechoslovakia had been occupied by Hitler since March. Very little time remained to make the necessary travel arrangements. Again, days and weeks of letters and interviews followed to wrest permission to leave the country. With what trepidation I waited for this permission which at any official's whim might have been denied! When my application was finally approved, willing I was indeed to sign that I would leave home with only my personal possessions, the ticket for the trip, and not more than three dollars in currency.

It was a relatively simple matter to obtain a student visa from the American Embassy for entry into the United States once I had approval from the German authorities in hand. When the Cunard White Star Lines notified me that I had a reservation on the *Athenia*, I was set for departure.

The final preparations for my leave-taking were not so easily made. Because I was to travel on a student's visa, I was required to buy a round trip ticket for the journey. The additional expense reduced my family's tight finances to an even more straitened

I was shaken by the realization that I had slipped through Hitler's tightening tentacles by the slender margin of one day.

condition. Despite my hesitation at placing this extra burden upon them, my parents insisted that I proceed.

The day of departure was August 29, 1939. It turned out to be the most difficult day of my life. How does one say goodbye to one's elderly parents? The last moments were filled with small talk which served only to camouflage the depth of feelings incapable of expression.

I never saw my parents again. Twenty months after I left home my father died, and two and a half years later my mother met her death at Auschwitz.

For me the future beckoned. Suitcase in hand, the Harvard letter safe in my pocket, I left Prague on an express train for London. The scheduled thirty-hour trip lengthened into a seemingly endless three-day journey, with delays caused by the many major troop movements through Germany.

Finally, on September 1, after a rough crossing of the English Channel, I arrived in England. The first news I heard in London was from paper hawkers shouting that German troops had invaded Poland. I was shaken by the realization that I had slipped through Hitler's tightening tentacles by the slender margin of one day. I was also sobered to know that the way back was unalterably closed.

With the resiliency of youth, my thoughts turned toward the next lap of my trip. Spurred by the narrowness of my escape from the Continent, I hurried to the Cunard office to confirm my passage to America. There I encountered an unforeseen obstacle.

In great dismay, I learned that my berth on the *Athenia* had been given to another passenger. Having no alternative, I accepted a reservation for the *Acquitania*, which was to sail a few days later. Fortunately, to offset the inconvenience, the steamship line assumed responsibility for the expense of my added stay in London. I was able to keep my precious three dollars intact.

On September 6, as I was about to board the *Acquitania*, I heard with horror that a German submarine had torpedoed and sunk the *Athenia*. Even while commiserating over the unfortunate fate of the victims, I was overwhelmed to realize that once again I had been spared. I could hardly contain a growing impatience to reach my destination.

For eight tense days the *Acquitania* pursued a cautious zig-zagging course across the Atlantic. During that time, I began to practice my limited knowledge of English on tolerant shipboard acquaintances.

I arrived in New York on September 16 with two dollars in one pocket (one dollar having been spent during the passage on tipping!) and the letter of acceptance to Harvard still tucked reassuringly in another. During the bus trip to Boston, thoughts of the past were suspended by anticipation of the challenge ahead.

At last I found myself in the Dean's Office at the Medical School. Presenting my precious letter, I stood there speechless, at once eager and shy, completely overcome with gratitude.

There are a few more remarks I would like to make:

It was through the humanitarian efforts of a committee of students and professors at Harvard College that money for Harvard scholarships had been collected for promising refugee students. Of the 21 students selected, two were unable to escape. The other nineteen and I—the only medical student among them—were saved.

And now I will admit to my real motivation in coming to speak today. Actually, it's two-fold.

First, I feel that those of us who were touched by the Hitlerian era have an obligation to speak out so that this terrible time continues to be remembered. We must refute those who claim that the atrocities of the Holocaust never occurred.

And finally I feel compelled to speak out against a new holocaust that is looming. I refer to the nuclear threat that may overcome all of mankind.

This time we should all stand together and work toward a peaceful world in which we can enjoy many more reunions at HMS. □

Walter Pick '42 is a pediatrician in Fitchburg, Massachusetts.



A History of the Harvard Medical Alumni Association

by Jane G. Schaller

The Harvard Medical Alumni Association is the sum of its parts: you and I, our predecessors, and those who will come after us. As of this Bicentennial, our Harvard Medical ancestors go back nearly 200 years, although a formal association of alumni did not come to pass until much later. It is not surprising that the organization of HMS alumni coincided with the Eliot years—a time when the Medical School as we now know it began to take shape through a series of vigorous educational reforms introduced by Harvard's famous president.

The first leader of the Alumni Association, Dr. J.R. Chadwick, stated: "The movement which has resulted in the formation of this Association did not have its origin in the minds of a few restless spirits. We were incited to the step by a wide-spread and ever-growing sentiment among the alumni that we can be of more use to our school in its efforts to raise the standards of medical education when banded together as an organization than we can by our individual exertions."

The first annual meeting of the Harvard Medical School Association

was held in Boston on Tuesday, June 23, 1891, and the manner of formation of the Association was thus accounted in the minutes: "A meeting was held at the Boston Medical Library November 26, 1890, of gentlemen interested in the formation of an alumni association of the Harvard Medical School. . .

"It was unanimously voted to form an association of alumni of the Harvard Medical School. This was decided upon, and after a careful discussion of the various aspects of the question, a committee of organization was appointed, consisting of Dr. J. R. Chadwick of Boston, Dr. F. H. Brown of Boston, Dr. H. P. Bowditch of Boston, Dr. G. E. Francis of Worcester, and Dr. L. R. Stone of Newton."

The minutes went on to tell that four additional planning meetings had already been held with considerable dispatch. A constitution had been drawn up, a council elected which would serve as governing body of the Association, a "Committee on the Harvard Medical School" appointed to look into matters deemed important to the Association and the School, and plans laid for an annual dinner meeting of the entire Association.

The Treasurer's Report included a first annual budget of \$1,182, with current funds of \$957.91 deposited "to the credit of the Association in Cambridge Savings Bank, book number 28170, drawing interest at 4%."

The serious business of the meeting being finished, members of the Association, 194 strong plus two invited guests, adjourned to the Hotel Vendome for a gala dinner and program. Dr. Chadwick gave an erudite talk about the Harvard Medical School and its current situation, and also announced that the Faculty of the Medical School had just voted that a four-year course of study be required of every student entering on and after September, 1892.

Dr. Chadwick also made a strong plea that graduates of the Medical School have rights in election of the Board of Overseers of the University. He concluded his address with a solemn quotation from the Talmud: "The time is short, the work is great, the reward is also great, and the master presses. It is not incumbent upon thee to complete the work, but thou must not therefore cease from it."

A number of letters of good wishes from illustrious persons were then read. Dr. Oliver Wendell Holmes wrote a delightful letter expressing his regret in not being able to attend the meeting. "I send my heartiest greetings to the Association. I know the members would receive me kindly as a relic of the past, not without a certain value as a fragment of antiquity. I have long been the sole survivor of that primeval Faculty of which I became a member in 1847. In that point of view, I am not merely a rarity, I am a unique specimen, and have an adventitious market price, like one of those rare cents for which collectors pay a premium. Half worn-out old copper as it is, its scarcity makes it worth a dime or, perhaps, a dollar.

"In the days to which I refer," Dr. Holmes continued, "the Faculty could say of itself, in the words of Wordsworth's little girl, 'We are seven.'" He went on to describe five of his six compatriots in witty and warm tones: John Ware, Jacob Bigelow, Walter Channing, George Hayward, and John Jackson. He mysteriously mentioned that "One name must be passed over in silence: It is too well remembered without being spoken." This perhaps refers to an unfortunate faculty member who was convicted of murder and died by hanging. Dr. Holmes con-

cluded his letter: "I will close at once by wishing long life and long prosperity to the Association of the Alumni of the Medical School of Harvard University."

The Report of the Committee on the Harvard Medical School was then presented, a concise description of the status of the school. A number of toasts were then proposed: "To the Corporation of Harvard University" (respondent Dr. H. P. Wolcott), "To the Overseers of Harvard University" (respondent Dr. G. B. Shattuck), "To the Medical School of Harvard University" (respondent Dr. H. P. Bowditch), and "To the physician as a legislator" (respondent Dr. Robert Davis of Fall River who was, in fact, a Congressman from Massachusetts).

The meeting ended with a touching tribute to senior faculty members: "The members of the Harvard Medical School Association, assembled at their first annual dinner, desire to send to Dr. D. Humphreys Storer, Dr. Oliver W. Holmes, Dr. G. C. Shattuck, and Dr. Henry Ingersoll Bowditch an expression of the sincere feelings of respect which they entertain toward them—the senior members now living of the Faculty of the Medical School—to express to them the grateful remembrance of the kindness with which they were received as young men, and led on step by step through the studies of the profession to which they have given their lives; and they venture to offer the hope for their long continued lives and happiness and the well-deserved appreciation of their brethren and of the community at large."

In 1892, the first listing of members of the Alumni Association appeared. A total of 1,011 members were listed, of whom 705 were from Massachusetts. A few brave alumni had penetrated as far away as the wilds of Pennsylvania (4), Ohio (5), Arizona (2), Montana (2), and even Washington State (3), including one Thomas William Musgrove, M.D. 1871, who received his mail at P.O. Box 289 in the hamlet of Puyallup, Washington, which even today is considered a severe test of pronunciation of native American names.

Of these 1,011 members, only twelve had paid the \$20 lifetime dues; the other 999 were presumably \$1-a-year members. Incidentally, it was decided some time later that even a dollar a year was too high a price to belong to the alumni organization, and

The goals of the Association remain much as they were in 1890: "To advance the cause of medical education, to promote interests and increase the usefulness of the school, and to promote good fellowship among the members."



now we are all welcomed as members for no dues whatsoever.

Much more could be told of early and later Alumni Council and Association meetings. The minutes of these meetings still exist in the Alumni Office and make fascinating reading. Since the first meeting of the Alumni Association in June of 1891, there have been 88 annual meetings, peopled by a myriad of eminent and illustrious individuals who have served the Alumni Association and Council in one guise or another. The annual dinners were abandoned as too large and unwieldy just after the turn of the cen-

tury and replaced by smaller class dinners. Over the years, a number of important issues have been addressed by the Alumni Council, and a number of heartwarming and humorous incidents have also occurred.

The Alumni Association and Council have provided some valuable services to the Medical School. Two noteworthy achievements include the building of Vanderbilt Hall and the inception of teaching in the field of industrial medicine. Around the turn of the century it was realized that the Harvard medical students "now had a good place to work but no place to eat,

sleep or exercise," and plans were discussed to construct a dormitory. The matter did not move very swiftly, and in 1912 a committee of students again expressed need for a dormitory. Plans then were interrupted by the First World War.

With the advent of Dr. Elliott P. Joslin as president of the Harvard Medical Alumni Association in 1922, plans for the construction of the dormitory began to move rapidly forward under the sponsorship of members of the Medical Alumni Council. The Council mounted a campaign for funds, and by June of 1924, a total of \$89,346.85 had been donated by 1,322 alumni. This was capped off by two very generous donations from Mr. Harold S. Vanderbilt, a 1907 graduate of Harvard College—hence the name Vanderbilt Hall. It was thus the Alumni Association that provided the impetus and means for the construction of Vanderbilt Hall, just as the Alumni Association has provided the impetus and means for recent renovations in the dormitory.

The subject of industrial medicine first came up at an Alumni Council meeting on December 4, 1917, with the following motion being passed: "The council of the Harvard Medical Alumni Association begs the Faculty of Medicine to consider the advisability of building up, with the aid of and in connection with the employment bureau of the Association, a center of industrial medical employment, and in case such a measure should be deemed advisable, also to consider the best means of putting it in operation." The Faculty of Medicine on March 29, 1918, voted that teaching and research in industrial medicine should be started under the Department of Preventive Medicine and Hygiene.

It is of some interest to note that the first woman appointed at Harvard became the first teacher of industrial medicine. In 1919, Dr. Alice Hamilton was appointed to the Faculty, but only after she accepted three conditions: 1) Never to enter the Harvard Club; 2) Not to participate in the commencement academic procession; and 3) Not to receive the professional privilege of a quota of football tickets.

Now I suppose one could survive without entering the Harvard Club, and not marching in the commencement academic procession would save shoe leather; but I submit that not receiving a quota of football tickets is a truly grievous insult, certainly not

The first annual meeting of the Association concluded with a tribute to senior faculty members from the alumni, who expressed "grateful remembrance of the kindness with which they were received as young men, and led on step by step through the studies of the profession."

defensible on any terms. One can only hope that Dr. Hamilton didn't like football in the first place.

In 1926, the Council established the *Alumni Bulletin*, a publication of considerable literary merit which continues to be distributed free of charge to all alumni. The purpose of this publication was well stated by Dr. Truesdale, then president of the Alumni Council: "Through the medium of the *Bulletin*, your Council plans to supply every member of the Association with news concerning the activities of the Medical School, references to the more important problems which are engaging the thought and zeal of laboratory experts, recent discoveries, changes in the system of medical instruction, with personal items renewing the acquaintance of the school with its graduates and the graduates with each other."

In 1950, the Council voted to establish a permanent fund and accordingly, under the aegis of Dean Berry, the Harvard Medical Alumni Association Fund became an integral part of the Medical School. In 1951-52, the first Director of Alumni Relations, Thomas Lanman, took office; he was later aided and abetted by a redoubtable Associate Director, Dorothy Murphy, who herself wrote a sparkling account of the Alumni Association. *Bulletin* Editor Gordon Scannell '40, Alumni Fund Chairman Carl Walter '32, and Director of Alumni Relations Perry Culver '41 are the current inheritors of these responsibilities, serving their fellow alumni with skill and dedication.

The Alumni Association and Council continue to function with a structure remarkably similar to that which was first set out in 1891. The "Committee on the Harvard Medical School" of 1891 has now taken the form of the Alumni Survey Committee, currently under the direction of Henry Vaillant '62, with the recent

leadership also of Carl Akins '66 and Edward Ahrens '41. The Survey Committee has recently looked into important matters such as premedical education at Harvard College, the problems of student housing, and the status of the clinical clerkships at HMS. Most recently, the alumni have even been accorded an administrative representative, Dan Federman '51, who now holds the awesome title of Dean for Students and Alumni/ae.

Thus, in 1982, I am pleased to report to you that the Alumni Association and the Alumni Council remain alive and well, even vigorous. The goals of the Association remain much as they were stated in the constitution devised by the gathering of gentlemen in 1890-91: "To advance the cause of medical education, to promote the interests and increase the usefulness of the Harvard Medical School, and to promote the acquaintance and good fellowship among the members of the Association."

By the definitions and traditions of Harvard University, this University is said to belong to the alumni. We as medical alumni embody the history and traditions of the Harvard Medical School, and we also number among us the newest recipients of its medical education. As a group we have much to contribute concerning both perspective and directions, not only for the present, but also for the future course of the school. Herein lies one of the great strengths of this institution. And so today, welcoming yet another class of alumni to our ranks, we will go on making history, gently, persuasively, and above all, in a comradely fashion. □

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Class Day 1982



PHOTOS BY JERRY BERNDT

How Are You Feeling?

by Daniel A. Goodenough

In thinking about what I would like to say in the brief time allowed, I find that I am filled with gratitude. I would like to begin by welcoming the families of the graduating class. What has become clear to me, as I have come to know your sons and daughters, husbands and wives, brothers and sisters, is what very special families you must be. Not only have you made personal sacrifices to cope with the staggering tuition costs, but the richness, variety and wisdom of the graduating students tells of remarkable childhoods, filled with connection and love.

The openness, curiosity and enthusiasm of these graduating students are a constant source of joy for me; and I am sure I speak for all of the faculty who have had the privilege of teaching and learning from these people. You families have good reason to be proud at this moment, not only of the achievement of the past four years, but for your parts in nurturing the total development of this remarkable new generation of physicians.

My most heartfelt thanks goes to the graduating class itself. To explain the origins of this gratitude involves relating some of my personal history, part of which you, the graduating class, already know, since you are an integral part of it.

I began teaching histology as a graduate student. After a while, I came to the unsettling conclusion that something was wrong. I was teaching only about parts of the body—organs made of cells, cells of organelles, organelles of macromolecules; but I was not teaching about whole people.



Perhaps I should be teaching gross anatomy, I thought. But a cadaver isn't a whole person either. Not only are cadavers not alive, but their contexts are unknown: the family, friends, religion, hopes, fears—all those social and psychological factors that make up a person.

It is true that our curriculum has numerous course offerings in social disciplines, as well as scientific ones, but this, I think, is not enough. The real challenge to me comes in trying to integrate the scientific with the social. Certainly all of us here today have the expectation that a physician will be a whole person, both scientific and compassionate, both able to analyze and able to join.

These thoughts left me in a somewhat uncomfortable dilemma. If my assigned task is to teach the structure

Daniel A. Goodenough, Ph.D., is Professor of Anatomy at HMS. He was selected by this year's graduates to be the faculty speaker at Class Day.



of cells, tissues, and organs, how can I do that while simultaneously generating a dialogue about feelings and social contexts? How can caring be integrated with collagen? And what if you, the students, finding any attempts to perform this synthesis ridiculous, were to stare in disbelief that I should even *suppose*?

On the other side of the podium, where were you, in that first semester at medical school? Those were the moments when expectations were confronting reality. The expectations included medicine, hospitals, sickness, cures, death, excitement, challenge, prestige, and money. (By now, some of these expectations have been realized, some were naive; some you still hope for, some are inevitable.) How would you respond to the inclusion of affect with adipose tissue? And yet affect must be integrated in the teaching;

since your patients would expect it of you as doctors, you expected this synthesis of us as teachers. There was no alternative but to try.

So, one December morning, I am standing before you in Amphitheatre C, my tongue a dehydrated piece of jerky stuck to the roof of my mouth. I give the last lecture in the course, on the histology of our special sensory organs, the eye and the ear. We marvel together at the incredible precision and beauty in the structure of the eye and ear, lending credence to the belief that we all see and hear the same sights and sounds.

I then hold my breath and begin to talk about feelings. Although I cannot show you any histological slides of feelings, we all have them. Feelings and affect are not understood in molecular terms, and hence they are often ignored in science; but they are

real, and we all experience them with the same intensity as we perceive light and sound. I go on to mumble about how easily we ignore our feelings, and how through repression and denial we become less sensitive to ourselves and to each other. I urge you to join with each other, to include cooperation with competition.

We talk about the dialectical balance between power and meaning, how you are in positions of little power as first-year medical students, and how that makes you feel. But soon you will have power, enormous power, the power of life and death, the power to heal and cure. This power must be balanced with meaning. You must give power back to your patients, by joining, by yourselves becoming teachers.

Normally, when one gives a lecture to 200 people, there is a certain amount of background noise, rustling, cough-



ing, pencil dropping and snoring. But at this moment, on this December morning, there is absolute silence. Every eye is on me. In the silence between sentences, I hear only my own pulse in my ears. At this moment, when I feel that I am hanging on the edge, you teach me the most profound lesson. You are not laughing, bored, or disgusted; you are intensely interested. I stop seeing the classroom as a collection of separate persons, and I see us as a connected whole, joined together in a common meaning. In that moment, I receive a tremendous validation. You do not laugh, you give me courage. You let me know that I am saying something that you want to hear, need to hear.

That brief discussion we had on that December morning hardly brought about a total synthesis of cells and feelings, but it began the process for me

of bringing feelings into that space with the cells. My colleague in teaching histology, Marian Neutra, already knew much about this synthesis. She teaches and joins with every sentence, captivates and connects with every lecture. I owe Marian and all the histology instructors my thanks for their support and their connected effort in the process of bringing themselves into our course.

But the largest measure of thanks today goes to you, the Class of 1982. You have taught me self-conviction. You have taught me that what counts is not only biological facts, but also what we do with each other around those facts. There is more than simply the control over a huge amount of information in medicine. There is also how we share that information with each other.

So the question asked four years

ago is still there: How are you feeling? What is our capacity to bring our feelings and our inter-connectedness into medicine and research? Can our daily rat race of trying to do everything at once be integrated with our ecological selves, our membership in the family of earth? Can we compete and yet still join? Can we be both self-assertive and affiliative? The answers are not known to me; I too struggle with the questions. I believe the answers lie in our ability to balance power and meaning, in our ability to look into ourselves, and each other, and find both our maleness and our femaleness—for we each have both—and to bring them out into the sunlight of our daily lives.

I thank you, Class of 1982, for teaching me this in a moment of great vulnerability. I thank you, families of the Class of 1982, for sharing these wonderful people with me. □

REUNION REPORTS



Fifty-fifth Reunion

Twelve members of the Class of 1927 attended Alumni Day exercises, and a class photo was taken on the steps of Building A. Through the efforts of a committee consisting of Alex Marble, Sam Epstein, Charlie Kickham and Jim Sacchetti, a reunion dinner was held at the Harvard

Club. Perry Culver, Director of Alumni Affairs, presented a nostalgic movie of the Medical School and spoke briefly on the past, present, and future of the school.

— James V. Sacchetti

Fiftieth Reunion

Thirty-eight members (sixty percent) of the Class of '32 returned for an inspiring 50th reunion. A large contingent attended the scientific sessions on Wednesday and Thursday. Our commitment to current affairs was also expressed in the overt admiration of Jane Schaller '60, the new president of the Alumni Association. Although it took awhile, most of '32 is reconciled to the acceptance of women at "our" school. We were honored by Jane's presence at the Class Dinner.

The Retrospective on Tuesday—conceived, promoted and moderated by Carl Walter—addressed the changing patterns of disease, diagnosis, treatment and teaching since graduation. The fourteen papers presented were a concise summary of progress in medicine viewed over a professional lifetime. John Brooks '43B provided glimpses of the Boston medical dynasties at HMS prior to World War I. Claude Welch moderated a panel of personages from the past—appropriately costumed and bewhiskered—who characterized various chapters in Harvard medicine. Richard Warren '33, speaking for his ancestor John Warren; Lamar Soutter '35 for Oliver Wendell Holmes; Howard Ulfelder '36 for Henry Jacob Bigelow; and Francis D. Moore '39 for Edward Churchill brought down the house.

The social festivities began with a reception for the emeritus professors and the Class of '32, hosted by the Dean and Mrs. Tosteson at the Science Museum. The group was joined by other alumni at the first Alumni Association dinner since 1901. Lewis Thomas '37, whom the Dean dubbed "The Bard of HMS," recited epic poems about the Medical School and the City Hospital.

Classmates were delighted when the Dean presented a seventeenth-century engraving, Mark Catesby's "Mahogany Tree," to Carl Walter in appreciation of his service as Chairman of the Alumni Fund.

As guests moved to view fireworks over the Charles, an accident on the escalator sent Stafford Wearn and Leonard Brewer to the Emergency Ward of the MGH. The fireworks were so startling, noisy and beautiful it was difficult to decide whether to celebrate the past or rush to the challenges of the future.

Wednesday evening's festivities focused on "HMS at the Pops." The event was also organized by the Class of '32, and hosted this year's graduates and their guests, thus celebrating the entry of the Class of '82 into our profession. Symphony Hall was jammed, with good reason: Harry Ellis Dickson conducted, and Richard Kogan '82 was the soloist.

The Class Dinner at the Ritz Carlton on Thursday was the social highlight of the 50th Reunion extravaganza. A clamorous cocktail jamboree of good fellowship



mellowed the group for a gourmet dinner embellished with rosé wine (Chateau d'Aquera, Tavel). Each bottle bore a commemorative gold label declaiming "The 50th Reunion of the Class of 1932." Not only were glasses refilled, but a corked bottle was given to each classmate. The wine was a gift of Mark Altschule "in gratitude for your friendship these many years." Mark, we love you.

The Reverend Doug Krumbhaar, who switched professions in mid-stream, said grace with charm and dignity at an opportunistically quiet moment during the course of the dinner. Both Brewer and Wearn—the latter scarified but undaunted—added to the fun. Ted read verses commemorating his encounter with the escalator.

We enjoyed the company of Elizabeth Houghton. Some of us had visited the Bird Dictionary (a gift of John Houghton) at the Science Museum and saw an unappreciated facet of our singular, taciturn classmate John. Unfortunately, Mrs. Benjamin Carey's visit was cut short when her car was stolen. Mrs. Robert Jennings was overwhelmed by emotion and departed for home early.

At the Alumni Day program Perry Culver directed attention to the colorful banners hanging between the columns of Building A. These regalia are a special 50th anniversary gift of the Class of '32 to the Alumni Association to add pomp to exercises on the Quadrangle. Carl Walter reported that the Class of '32 is still the champion, both in percentage of contributions and accumulated gifts to the Alumni Fund.

We unanimously elected a slate of class officers: John Ham, president; George

Wilkins, vice-president; and Jim Mansfield, secretary-treasurer.

Seventeen couples shared the We-quassett Inn in Chatham on Cape Cod with the Class of 1947. Despite the cloudy sky and the chilling wind, the high spirits continued amid the delightful surroundings. Cocktail parties followed by a scrumptious dinner Friday and a well staged clambake Saturday were each topped off by George Wilkins (1932's answer to Richard Kogan) at the piano.

During the festive week an emotional ground swell resulted in the conclusion that at this stage of the game reunions should be held every year, with appropriate awards by the Alumni Association to attendees. For the 55th, Bud Stillman invited the class to his aloe and citrus ranch on a "resaca" surrounded by the Rio Grande near Brownsville, Texas, and for a ride on his refurbished parlor car, "The Texas Cannonball."

— Eugene A. Gaston

Forty-fifth Reunion

Thirty of our classmates, plus an equally large contingent of spouses, relatives and/or other close friends, convened for our 45th—one of the most enjoyable reunions we've experienced to date!

Several of us attended a gala reception Tuesday evening at the Museum of Science, hosted by the Class of '32 and the Alumni Association, where the principal speaker, our illustrious classmate, eminent scientist, essayist and poet Lew Thomas, read some

45th Reunion continued

of his nostalgic odes and sonnets to the delight of all.

At HMS Night at the Pops the following night, we '37ers were seated in close proximity at wine laden tables strategically located on the orchestra floor of Symphony Hall and were treated to a great concert. On Thursday, the third and concluding day of well presented and well attended scientific symposia at the school (participants including two from '37: Luke Gillespie and Lloyd Hawes), our class enjoyed hors d'oeuvres and cocktails at Vanderbilt Hall.

On Friday, the Alumni Day speakers having spoken, class pictures having been taken, lunch-on-the-green eaten, tents on the Quadrangle folded, our class took off by bus for Old Sturbridge Village. There, about sixty miles from Boston, we had a good look at some of old New England's arts, crafts, edifices and animals, as the prelude to a great dinner at the Village Tavern. Herb Katzin entertained us with an excellent sound movie presentation of his recent ophthalmologic activities in China. Then back to the bus and Boston. Finally, on Saturday we repaired to South Dartmouth, where Joe and Janet Frothingham hosted us at their lovely estate overlook-



ing Buzzard's Bay and we feasted at a clambake.

I think all of us felt it was a great week

and are already looking forward to our 50th!

— Charles P. Emerson



Fortieth Reunion

This year's reunion was memorable, coinciding with the school's Bicentennial; many classmates and families arrived in Boston in time to enjoy the whole week's events.

Thursday evening 87 class members, wives, and some older children assembled

in force; all enjoyed dinner at The Country Club in Brookline. Friday morning the clouds parted, sun shone, cool ocean breezes blew, and the usual Alumni Day program of short, incisive, and interesting talks were presented—including two from

classmates.

None of us had known Walter Pick's harrowing and fantastic story of his travels across Europe before the Nazi anchluss—through Czechoslovakia, Western Europe, and across the Atlantic, missing disaster by moments to hours. No more thrilling account could be told as everyone sat on the edge of his chair and no pin dropped. John Merrill delighted the audience with his account of life among the giants—those fabled teachers whom we were fortunate enough to know between 1938 and 1942.

That afternoon, many car pools permitted transport of 56 class members and families to Newport and the Goat Island Inn. A timely social hour and pleasant buffet supper there concluded the day.

Saturday presented sunshine and fresh breeze. A handsome schooner, *Charlotte Ann*, received half of the class at the Goat Island Dock for a morning cruise, favored by the day and the weather and the wind.

Returning at noon with a made-in-the-galley clam chowder and buffet luncheon, the morning group was replaced by another contingent. It was notable that no *mal de mer* was reported, although a few scopolamine patches could be seen over the mastoids.

Saturday afternoon Cheoy Lee yacht *Leucothea* sailed in from Cuttyhunk with sailor and film producer Chris Knight. That evening, at the Sheraton Islander, after the celebrants were finished with the social solvent and a fine dinner, Knight explained how the transatlantic multihull race of 1980

had been filmed, and the film *The Atlantic Challenge* was then shown—a unique close-up view of a 3,000 mile sea voyage. This remarkably interesting evening concluded with discussion about psychology, nutrition, tactics, and medical requirements for such adventure.

By Sunday morning, the June rain had resumed. Early departures got under way; and the hard core reunioneers lunched at LeBistro and then drove off through the

rains for Boston.

This was a grand reunion. Those who came rejoiced to have been able to and to have done so. There seemed to be a general spirit that we continue taking things for granted—pretty much—and that the good luck of this notable class has not yet expired.

Nothing would have worked out had it not been for Don Nabseth's careful, timely construction of the class history; John

Merrill's collection of the money and provision of good advice, so that a seemingly impossible set of expenses were managed without a deficit; and Oley Paul's support and counsel. We thank Perry Culver, Ralph Travis, and Jane Bruno in the Alumni Office.

— Melvin P. Osborne

Thirty-fifth Reunion

The 35th reunion of the Class of '47 and the opening of the school's Bicentennial celebration coincided to give us a memorable series of days and nights last June.

The number of pages of this issue of the *Bulletin* would rival the Federal Budget were we to recount the joy of those moments, from the opening sessions on the Quadrangle through the Evening at Pops, to the dinner at the Parris Room, and on to the weekend at Wequassett.

Bob Larimer's discourse on solo practice reminded us all of the essential one-on-one relationship of the clinician and patient; he then on Thursday night proceeded to conduct a musical quiz. The least changed (Braunstein and Zufall) and the most changed (Wake Up, Charlie Minor) designees are getting in shape for 1987.

As during previous reunions, we rejoiced especially in seeing those classmates who prior to this year had joined us infrequently or never.

The Wequassett clambake, indoors though it had to be, was made to sparkle by the presence of the Class of '32; may we be so clearly thriving at our 50th. Best of all was to look upon one another, our

wives, our families, and our achievements, and promise to repeat the gathering in five years.

Special thanks are due Nate Brackett for editing the Red Book; Jim Shannon for

handling the funds; and the Alumni Office staff, especially Virginia Linnane and Ralph Travis.

— John Duggan



Thirtieth Reunion

Not unexpectedly, our tried and true quinquennial reunion chairman, Mel Feldman, developed yet another excellent program, melding it nicely with the HMS 200th anniversary celebrations.

However, not until Thursday evening did we convene as a class, with cocktails and dinner at the historic Tavern Club—the cocktails and story swapping downstairs, and then an excellent dinner upstairs for about eighty of us. Besides the conversation about professional and leisure lifestyles, one could overhear throughout the pleasant evening discussions about grand children, as well as a few grandchildren.

Friday afternoon found a smaller yet hardy band of '52 trekking north to Whitefield, New Hampshire and Mountain View House, the latter well named. Al and Debbie Senft had left us for the nuclear freeze march in New York and others had fallen off the bandwagon for various

30th Reunion continued

reasons, such as children's graduations and the call of weekends on. Those who went north entertained themselves with golf, tennis, talking or climbing up hill and mountain. Evenings were spent reminiscing, mixed with dancing.

The Thorlaksons and Kraus's had travelled the farthest; the Moguls represented the strongest class affiliation (with the Haynes right behind).

In the words of the Irish, t'was a grand time, and the rest of you should have been there, for that way it would have been grander.

— William D. Cochran

Twenty-fifth Reunion

The Class of '57 has always felt good about itself, and this collective sense of approval has strengthened with the years. More than 75 classmates returned to attend the various activities in celebration of our 25th and the Medical School's Bicentennial.

During the last year, small groups of us had worked with both the Alumni Office and the Dean's Office to prepare for those festivities; and while the varied agenda of Alumni Week reflected the total effort of those involved, as in undergraduate days, control inevitably remained with the hierarchy: Final credit or criticism must repose with those in Building A. (From all appearances, both the historical program and the multiple social events were universally enjoyed.)

A feature of the 25th class activities is the scientific symposium, in which classmates report on original work with an in-



formality perhaps nowhere else enjoyed in professional bastions. If Perry Culver's reaction can be construed a true measure, then '57 has set a new standard for future reunions to emulate.

Evenings at the Pops and the downtown Harvard Club were both well attended and enthusiastically celebrated. On Thursday this mood was briefly suspended while a silent tribute was extended to those no longer with us in the daily struggle. Following the traditional Friday luncheon in the Quadrangle, which fortunately this year exacted no apparent gastrointestinal toll, the Class of '57 adjourned to York Harbor, Maine.

I doubt that we could have found a more enjoyable place than the Stage Neck Inn to renew old friendships and discover new insights a quarter century later. Maine is not warm in June, however; and in deference to this unyielding fact, Saturday's clambake was judiciously moved indoors. The lobster was good, but the songfest was better.

It was good to see all of you. We are, indeed, a helluva class!

— Daniel J. O'Connor, Jr.



Twentieth Reunion

All things considered, we were well represented at the Alumni Week Bicentennial celebrations. Several members of our class, including newlywed Eliot Berson, attended the dinner at the Museum of Science, and on the following evening at least eight classmates with wives and children represented '62 at the HMS Night at the Pops.

Our own class activities started Thursday evening at the Harvard Club, with a cocktail party which lasted until we closed this particular facility for the night. I would presume this means that everyone had a good time. The next day, as you can see from the accompanying photograph, a minimum number appeared at Alumni Day. There is hope, however, since we have increased our numbers quite significantly in the past five years ($P \text{ value} \geq 0.05$).

Fifty of us, including 28 class members, attended a reception and dinner Friday evening at the Parris Room in Quincy Market. The warmth and recollections,

highlighted by the first public appearance of Ellie Sorentino since graduation, more than made up for the light attendance. Choice remarks made after dinner reminded us all that George May is as shy, Dick Zimon is as loud, and Eileen Ouellette is as funny as ever. We were all delighted to see Bill Donahue looking so well only nine months following open heart surgery.

On Saturday over 100 of us gathered at

the Myopia Hunt Club for a clambake, tennis and softball. Although the pool was readied, the cool weather kept even the most strong willed from venturing forth. Three classmates managed a round of golf, which included a fine 79 for Bill Donahue (he wouldn't tell me what he got on the second nine).

There were several first-time returnees for reunion activities, including Larry

Zivin, Mike Oxman, and Sarah Plimpton.

Overall, 57 of our 134 classmates attended one or more of the events of the week. To those who came, I hope you had as good a time as I, and to those who could not attend, we hope you will reserve the time in five years for our noble 25th.

— Samuel H. Kim

Fifteenth Reunion

Something important happened on the way to our 15th reunion: seven of us died, three by their own hands. This number greatly exceeds that of the average class and moved three of us from '67 to publish their thoughts about it in this publication. Needless to say, it set the scene for this June's get-together.

About twenty of us gathered at my house Thursday evening for a cocktail party, which was certainly "essentially WNL." Its aftermath, though, really got our reunion going, as almost everyone stayed on for beer and pizza. It was really reminiscent of the Vanderbilt Hall dining room atmosphere, and the conversation went on and on, and on.

The morrow's Class Day activities might have been an extension of the night before, but I'll never know. I didn't get there — and no one mentioned anything about it to me. Which is also WNL.

That night, though, at the Tavern Club in downtown Boston, something special did happen. The club is old and wood-beamed, with red leather chairs, lots of wood paneling, and generally another reminder of old New England and VDB Hall. Upstairs, there was set for us a gargantuan "mead hall" table, arranged out of all of the regular tables together, with a huge bulge towards its center. All sixty or so of us sat at this one table — the whole class together. And that's what happened. The whole class was together. The only other time I can remember such a feeling of closeness among our class was at our post-second-year-show party, where we rocked, hard, all night long.

Maybe the meal helped set it up, for while tasty, it was short — and no one wanted to leave. H. Harris Funkenstein, our treasurer and senior officer present, was as sharp and in control as M.C. as he had been in the recent Rhode Island celebrity coma trial. And one by one almost all of us got up to say "a few words" — to keep us all there.

There were anecdotal recollections, but most of what I remember dealt with the years *after* HMS, the preparation we never got for professional life, our own reflections on life as a doc, our grief and anger over seven deaths from our midst. Hardly anyone seemed that pointed in what he or

she said, but as it went on, we knew that we were sharing some of ourselves with each other, some of our stumbling and groping as we balded and belied our way from HMS to forty. How it might have been better or easier. How we or our families or patients would have had it better and how we suffered on through.

There was no facade of "having it all together." Rather, it seemed like we were a family that came home for dinner like always and felt free to bitch, to get it off our chests, to say we liked each other — or didn't. I certainly felt a sense of strength from it, from a realization that my classmates could understand me and I them. We missed those of us who couldn't make it to the 15th and hoped they would to the 20th.

Saturday we went to the Cape, for a clambake at the Lighthouse Inn. Most of us hoped that what happened — I guess you'd best call it a kind of happening — the night before would continue. We tried, but it really couldn't. The weather was raw, the kids were running in and out, and, for whatever other reasons, it didn't.

Some of us talked about sending out

some biographical questionnaires to those of us who did not get them in for the class book. I hope we do and that we'll get some back and then mail copies out to all of us.

And let's hope we can pick it up again at our 20th.

— Mel Lurie



Tenth Reunion

The 10th reunion of the class of '72 began with a reception (read: cocktail party) at the home of Ann Bajart, and Tony and Alex (1 yr.) Schemmer. There was a gratifying turnout of over eighty classmates and family. Special live guest appearances by non-'72ers Dan Federman, the Liscos, the Feeneys, and the Gross's delighted old friends and former students.

Since a 10th is not without an element of self-assessment, it is with pleasure we

10th Reunion continued

report that all attending looked well. As the evening wore (tore?) on, one detected the common acceptance of a bond, indissoluble and welcome. Despite efforts to artificially prolong the party, conversations and meetings were regrettably short, a fault partly remedied by breaking into groups for leisurely dinners at favorite haunts.

Our class participation on the following Alumni Day was less stellar. Those of us who attended (refer to photograph) soaked up some blissful sunlight and sipped cool beer.

The Wychmere Harbor Club is the usual and customary location for an HMS 20th, just as is Perry Culver's backyard for a 5th. In this, '72 jumped the gun—and a smart thing too. The June weather was characteristically Baltic, but forbearant enough to permit indulgence in all featured activities—tennis, jogging, hiking—except blatant sun-worship. On the consolatory side, the moody overcast nurtured an intimate ambiance at the clubhouse's crackling fireside. Very conducive to mellow reminiscence and self-revelatory banter. Even the non-Nordic ventured into an extravagantly heated pool and sauna. Atlantic, who needs you?

We lingered over bountiful meals at long communal tables and peppered the talk with "what-ever-happened-to" inquiries about those who had not thought to attend and defend themselves.

A major focus of attention and conversation was the Next Generation—many of them present. A robust and lusty-looking



lot they were. Aged ten months (Zachary Abele Smith) onwards, they clutched at tablecloths, careened around tray stands, and made a general delight of themselves, indoors and out.

For this reunion, the palm must be awarded to the West Coast contingent, whose attendance surpassed (and shamed) that of those from the Boston environs.

This is a tribute to their splendid class spirit and a somber reflection on...? higher MTA fares.

For ourselves, we hope to be allowed to host the 15th right here in Brookline. Our house was never so neat, nor shall it be again until then.

— Ann Bajart and Tony Schemmer



Fifth Reunion

Our reunion began a bit slowly with the stalwart group who came to the scientific symposia sessions and posed for the reunion picture—most of us were still tied up in residencies and fellowships. However, the Friday night festivities at David and Mimi Steinhaus's home brought out a great crowd. A group of over seventy, from as far away as Texas, came to find out how we had all changed (in general not very much).

On Saturday Perry Culver kindly held his annual clambake, which was also well attended, although it was so cold that we were forced indoors around the fireplace! There were a few gray hairs and a lot of young children; most classmates seemed pretty settled and happy with their careers. Everyone was friendly and often pleasantly surprised with one another. We all had a marvelous time and are looking forward to the tenth.

— Tom Mustoe

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